DOCTOR OF PHILOSOPHY

Exploring the relationship between leadership, leadership behaviours and organisational culture

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Thesis submitted for the degree of PhD
University of St Andrews
University of Dundee
December 2010

"The NHS needs to attract great leaders into the service and unleash the full potential of those it already has."

Gander.P.2008:36

"Leadership has been the neglected element of the reforms of recent years. This must now change."

Lord Darzi 2008:66

"Leadership in organisations does not take place in a vacuum. It takes place in organisational contexts."

Porter and Mclaughlin 2006:559

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To my family in thanks for their constant support and inspiration

Chapter overview

Contents

List of tables

List of figures

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Finally my family and friends, and in particular I would like to thank my parents and brother for keeping me going, and my cat Sweep for always keeping me company.

I, Julia Anne Egan, hereby certify, that this thesis, which is approximately 100, 000 words in length, has been written by me, that it is the record of work carried out by me and that it has not been submitted in any previous application for a higher degree.

Date..... Signature of candidate.....

I was admitted as a candidate for the degree of PhD in July 2004; the higher degree for which this is a record was carried out in the University of St Andrews and University of Dundee between July 2004 and December 2010.

Date..... Signature of candidate.....

I hereby certify that the candidate has fulfilled the conditions of the Resolution and Regulations appropriate for the degree of PhD in the University of St Andrews and University of Dundee and that the candidate is qualified to submit this thesis in application for that degree.

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Abstract

This thesis explores the theme of leadership in the NHS, specifically focusing on nursing. Leadership has become an important area in recent years particularly in relation to improving efficiency, effectiveness and quality of services. As nurses provide 80% of care in the NHS their role is pivotal in achieving any change. Despite the importance placed on leadership in the NHS, literature shows little is known about perceptions of leadership, how leaders function or what importance staff place on the culture and context in which they work. This study is based on the findings of 28 qualitative interviews with leaders in two health boards in Scotland. Through the presentation of informants' perceptions, beliefs and collective accounts, the study illustrates how staff view leadership in the NHS and provides some significant results. Firstly, it proposes that leadership is comprised of two elements; one relating to individuals and one relating to how individuals function in organisations. Secondly, it indicates three models of leadership are particularly relevant and how these apply differ according to role and hierarchy. Thirdly, it reveals leadership and management as distinct components. In nursing a number of complexities make these roles challenging, and the culture and context of health boards influence how these function in practice. Finally this research concludes that staff value a clear set of characteristics, styles and behaviours not related to vision and change but which centre on character, values, integrity and engagement. The study has considerable implications for emerging work on leadership in the NHS and for the future development of leadership roles in nursing.

Chapter One

Prologue

Having worked in the NHS for over twenty seven years as a nurse and senior manager I have worked with some very good leaders but also some very bad ones. My interest in leadership began primarily in my last post after being promoted into a senior leadership and managerial role. The post was responsible for managing a large section of the organisation encompassing two Primary Care Trusts, three community hospitals and almost one hundred GP practices This involved responsibility for many health professionals, services and developments, including a considerable number of managers and heads of service. It became evident after only a short time that a number of managers seemed able and comfortable managing specific projects and budgets but struggled to manage and lead clinicians. A number appeared to lack basic interpersonal and adaptive skills and the leadership qualities required for their roles. Frequent negative feedback was received from members of staff who articulated difficulties in being managed and led by these managers. As a senior manager and leader I became interested and concerned in how we recruit and appoint leaders in the NHS that clearly lack the necessary qualities and skills and have the ability to negatively affect their followers' ability to carry out their role.

Following my subsequent appointment to one of the first non-medical consultant posts in Scotland, my interest in this area continued when colleagues appointed to similar posts struggled in their ability to perform as leaders within the organisations they worked. This appeared to be not from a lack of leadership skills but because the organisations they work in did not allow them to lead or fulfil their roles. Both of these experiences led me to explore the subject of leadership, leadership qualities and behaviours in the NHS and to consider the role of organisations in allowing leaders and leadership roles to develop and flourish in practice.

Having practiced as a nurse and nurse leader since the age of eighteen I strongly believe in the qualities of nursing; in what nursing has to offer students and clinicians as a profession and career and the benefits nursing can provide to patients. Both anecdotal experience and numerous policy papers in the NHS underline and discuss the importance of good and effective nursing leadership as being critical to good, safe patient care and to the effective functioning of wards, organisations and the NHS as a whole.

Whilst this experience is valuable, in relation to this research it is important to note any effects this experience and views had on the conduct of the study and account given. I reflect on this at various points in the thesis.

Introduction

This study examines the subject of leadership within the NHS. The matter of leadership and clinical leadership in particular has in the past decade become a subject of considerable interest both for a government wanting to promote reform and for a nursing profession given a greater role in the changing NHS. (Stanley 2009, Rafferty 1993, DOH 1998, 2000, 2003, 2003a, SEHD 2001, 2003a).

A number of problems face the modern NHS. These include the need for efficiency, effectiveness and quality especially on issues concerned with financial resource distribution and competing priorities. There is an increasing gap between commitments and resources. The need for change has not been helped by a complex hierarchy (Klein 2001, Hunter 2003). The NHS has struggled in dealing with the competing roles of doctors, experts, nurses and other professionals and in achieving a balance between central and local autonomy. With two decades of unprecedented reform for the NHS there is inevitably a greater emphasis placed on the quality of leadership and its willingness and ability to change organisational structures and to improve performance and output (Klein 2001, Hunter 1980, Harrison, Hunter, Marnoch and Polllitt 1992).

In the 1990s, the UK government sought to tackle deficiencies in the quality of care provided by the NHS via the introduction of governance mechanisms and structures (DOH 1998), which introduced processes dependent on a clear definition of standards of care and associated processes of delivery. Clinical governance in many ways has formed the centrepiece of all recent NHS quality reforms, with government guidance describing it as the 'lynchpin' of the quality strategy for the NHS, and outlining continual steps for implementation, quality improvement, and clear policies aimed at managing risks and poor performance (Spurgeon 2003). Key actions for implementation have included assessments of capacity and capability, the introduction of robust reporting arrangements, and at the centre, a

continual drive for leadership and accountability. The definition and introduction of clinical governance within the NHS combined elements of external quality assurance with internal quality improvements, and concerns were expressed around the creation of possible tensions in promoting both goals simultaneously (Davies and Mannion 1999, Spurgeon 2003).

Currently, as in UK health policies and plans, Scotland has put considerable emphasis on: the need to change culture, style and management; empowerment; training and education; workforce planning and on improving health and reducing health inequalities (Scottish Government 2005c). National standards have been set on local delivery, on increasing governance, accountability, streamlining bureaucracy, improving integrated planning and decision making together with the introduction of performance management frameworks, which assess health improvement, clinical outcomes, standards of service and set out accountability and review processes (Scottish Government 2005c, 2006). Many common features still exist with health policy elsewhere in the UK. However different solutions and organisational models have been introduced which reflect policy differences between Scotland and Westminster, particularly around structures, and roles of health boards and trusts. Despite these differences, the four UK systems have the same aims and face common challenges, particularly in relation to cost, quality and access.

Distinct changes have also been announced in the means chosen to achieve these objectives which include: local responsibility for the achievement of change, an emphasis on the need to change behaviours, rather than just tasks and structures, and acknowledgments that achieving health is not just about healthcare (Scottish Government 2005c, 2006). As a means of achieving these changes and delivering high quality care and treatment, there has been increasing emphasis on the importance of leadership as opposed to management – a distinction which will form a centrepiece in this study. This was reflected in the NHS Plan (DOH 2000) which

stated: *"Delivering the plans radical change programme will require first class leaders at all levels of the NHS"* (DOH 2000:86). *"We need clinical and managerial leaders throughout the service"* (DOH 2000:87). In Scotland *Better Health Better Care* (BHBC 2007) an action plan to support the Scottish Governments overall purpose for a wealthier and fairer, smarter, healthier, safer, stronger and greener Scotland also emphasised the importance of leadership: *"Leadership is central to improving performance, redesigning services and securing better outcomes for the people of Scotland"* (BHBC 2007: 14). BHBC was accompanied by BHBC: Planning Tomorrow's Workforce Today (2007a) which particularly highlighted the importance of clinical leadership.

More recently in the UK, Lord Darzi (DOH 2008) has argued that good clinical leadership is central to the delivery of any NHS modernisation plan, by emphasising that the NHS needs leaders who are willing to embrace and drive through the radical transformation of services that the Health Service requires (Hewison and Griffiths 2004). In articulating this need for differing and increased forms of leadership, all official policy documents advocate that a culture and climate of change needs to be created in the NHS, and that one of the ways of achieving this is via leadership (DOH 2002, 2002a, 2002b, SEHD 2005, 2005a). Underlying this is the notion that if appropriate models of leadership are adopted in the NHS it will lead to cultural transformation, improved quality of care, efficiency and effectiveness.

Recently, various high profile media cases have also raised the importance of leadership within the NHS. Examples where a lack of effective leadership, professional collaboration and team work have been an explanation for inadequate and fragmented healthcare practice include the public inquiry into cardiac surgery at Bristol Royal Infirmary and the death of Victoria Climbié (Laming 2003, Millward and Bryan 2005). A number of UK NHS reports and studies have also cited the absence of leadership as one or the main causes of safety or quality failures.

Investigation reports in this category again include the UK Bristol tragedy (Kennedy 2001), which noted senior leadership had not given the resources and the support for clinical audit - failures of care in which patients were at risk (Walshe, Hyde and McBride 2003, Walshe and Shortell 2004). Moreover, the UK NHS inspectorate reported that the breakdown of leadership is likely to have contributed to higher death rates in UK heart and lung transplant programmes (Kmietowicz 2001).

In recent years therefore it has increasingly become insufficient for managers just to run a service: they must now continually improve that service. This has created a shift in emphasis and importance for the government away from traditional management structures towards models of leadership, particularly clinical leadership. Successfully making any significant change in the NHS and maintaining high standards of care requires the ongoing trust and commitment of staff throughout the organisation. Clearly this has implications for leadership and management within the health service, and given that it constitutes one of the world's largest labour forces, employing around one million people (Bloor and Maynard 2001), any change impacts on the work of significant numbers of people. Society and business in most spheres accept that more employees and stakeholders now participate in management and leadership of some kind, contrary to past decades of hierarchical philosophies. A range of environmental pressures and challenges has driven a growing trend, both in the UK and internationally, towards changes in workforce configuration and skill mix in healthcare (Hyde, McBride, Young and Walshe 2005, Davies 2003). As these authors and Adams, Lugsden, Chase and Bond (2000) highlight, these drivers include: the need to respond to skills shortages, pressure for better management of labour costs, a desire to enhance organisational effectiveness and changes in professional regulation. The absence of strong leadership has been felt to have had a significant impact on the ability of healthcare systems to implement and sustain strategic change initiatives (Degeling and Carr 2004), and it could now be argued that without transformational leaders who are able to inspire and engage people in a

shared vision for the future, sustainable healthcare reform is not possible (Block and Manning 2007:85).

Despite these concerns and investment in the NHS by the UK government over the last decade, its performance was regarded as disappointing by Wanless in 2002 which has meant it remains the focus of increased scrutiny by politicians. This has been seen in practice by the increased use of targets, audits and performance reviews, despite the fact that such regimes have led to a reduced sense of confidence in leadership capacity by NHS Chief Executives (Blackler 2006) - the people said to be crucial in terms of leading and creating the effective leadership and organisational culture to achieve modernisation required (Alimo-Metcalfe *et al.* 2008).

Previous audit commission reports (1997), and various other recent papers have also identified that good or bad managers are the biggest cause of staff turnover between NHS trusts, with managers often reported by respondents as being the sole cause of high turnover in a particular department (Flanagan 1997). This has been reinforced by the author's anecdotal experience. High levels of turnover are disruptive, reduce quality of services, incur costs and increase stress levels of remaining staff (Flanagan 1997). An article by Wall (1997) on the motivation and reward of managers identified the need for a culture change if the NHS is to improve the motivation of staff and managers. It points out that managers are often required to work in a situation that exceeds their current capability, which can be highly stressful and which then can perpetuate inappropriate styles of leadership and management, again an issue substantiated by anecdotal evidence. As a large percentage of managers are nurses, their role and their ability to function effectively as leaders is of critical importance. If staff are to treat patients well then organisations need to treat their staff well. Organisations reveal their policies and values through the actions of their managers. Managers who feel undervalued and increasingly stressed will not be the most mindful of the sensitivities of their staff

(Wall 1997). Organisational success in obtaining its goals and objectives depends on managers and their leadership style. By using appropriate leadership styles, studies suggest managers can affect employee job satisfaction, commitment and productivity (Alimo-Metcalfe *et al.* 2008).

Both the interest and urgent need for leadership in the NHS therefore, has led to the launch of a number of major leadership initiatives in recent years, all of which are distilled in the NHS and Scottish Health Plans (DOH 2000, SEHD 2000). A modernisation agency was established (more recently known as the NHS Institute for Innovation and Improvement) to develop, implement and oversee various leadership initiatives, all of which are now coordinated by a designated leadership centre established in May 2001. Such initiatives include clinical governance, primary care group leadership, chief executive and clinical leadership development (Millward and Bryan 2005). These argue that integrated care is only possible if professional and organisational barriers are broken down and a culture of shared governance is developed, where staff are enabled to accept responsibility and accountability at all levels of the organisation. In practice this involves: *"clinical audit, risk management, user involvement, evidence based practice, continuous professional development, management of inadequate performance, reflective practice, team building and team review"* (Millward and Bryan 2005: xiii).

In 2002 - 2004 the Scottish Executive Health Department and the UK based Leadership Centre both published definitive and consultation documents on the nature of leadership competencies which they believe need to be nurtured and developed in the NHS (SEHD 2004, DOH 2002c). Their aims were to outline recommendations for the strategic development of leadership and management in the NHS and to create momentum in organisations to meet and embrace the change agenda they face. More specifically, the reports included a list of competencies and attributes. But debates have still existed around what kind of

leadership is effective and how leadership is distinct from or additional to good management.

Leadership development has therefore been seen as central to the modernisation agenda of the NHS. It has been identified in all recent key policy documents. A range of leadership development programmes have been developed to meet this need, and it is clear that there has been a great deal of work and investment going into the development of leadership in the NHS at national, regional and local levels (Edmonstone and Western 2002, DOH 2000). The Royal College of Nursing (RCN) Clinical Leadership course which started in 1994 has now been attended by over 2000 nurses from 140 NHS trusts in England, Wales and Scotland (Pearce 2002), and evidence of their effectiveness is now beginning to emerge (Hewison 2004, 2004a). However, Edmonstone and Western (2002) found confusion among programme participants and NHS employers around the appropriateness of particular programmes for particular groups of staff, suggesting that discussion is needed to explore the assumptions underlying approaches to leadership development in the NHS. In evaluation studies they noted that no attempt had been made to establish baseline measures of leadership effectiveness. No specific organisational benefits were identified and there was no consensus over what organisational benefits might be anticipated. It is thought this may be because leadership models created for a very different environment may have little relevance in an era of radical health reform (McCallin 2003:369). The need to support participants once the programme is completed is also highlighted, together with the fact that in many trusts an overall approach to leadership and organisational change was lacking. This suggests that leadership development for individuals will only bring about the anticipated changes if the organisations within the NHS allow, and indeed enable, leaders to lead, and also highlights that leadership is only one element in the management and organisation of health care (Hewison and Griffiths 2004). This study will clarify and analyse these problems.

In line with national UK policy 'Delivering through Leadership', the NHS in Scotland's leadership development framework was published in June 2005, (SEHD 2005b). This framework and its supporting implementation plan aimed to build leadership capacity and capability in NHS Scotland and create new leaders to meet these challenges. It was intended to represent a single national approach to leadership development in NHS Scotland, focused on the needs of the service, teams and individuals. Significantly, the framework places great emphasis on the importance of personal qualities, service priorities and organisational culture in developing leadership capacity and much less on seniority and hierarchy. Developing leadership potential is recognised as appropriate for people throughout the service. BHBC (2007) included action to review this framework, and to clarify leadership qualities and behaviours required to deliver new priorities.

Criticisms highlighted within debates are that the framework encourages too much emphasis on vision and inspiration, and too little on the need for understanding the complex context in which leadership in healthcare takes place (Alimo-Metcalfe and Alban-Metcalfe 2006, Alimo-Metcalfe *et al*. 2008, Edmonstone 2008, Wood and Gosling 2006). This argument can also be applied to almost all notions and models of leadership, which can appear as somewhat superficial and simplistic, given that leadership is complex and possibly dependent on context and environment. Inevitably the development and behaviour of leaders within the NHS will be influenced by the structure, culture and climate of organisations. It is unfortunate that traditionally within the literature, faith appears to have developed in certain leadership models which often appear to focus on competencies to solve the problems in health reform. This study will show they have been founded on concepts of leadership that appear to have failed to understand the context in which leadership in the NHS must be enacted.

As eighty per cent of the workforce in the NHS consists of nurses and midwives, and nursing forms the largest and most expensive component of the NHS budget

(O Neill 2000, Hennessy and Spurgeon 2000), it would be strange if politicians were not interested in ensuring the existence of a safe, competent, cost - effective nursing workforce able to meet demands across the service. As nurses deliver constant, twenty four hour care, success in developing many reforms depends heavily on their roles and contributions. The idea that nurses and other professionals should play a critical role in implementing this new NHS vision therefore is not a surprising development, and in response a large percentage of leadership challenges have been directed at nurses, nurse managers, and directors of nursing services. Stronger nursing leadership has been described as crucial to the government's plans to modernise the NHS and to improve the public's health (DOH 1999:4), and what has been proposed has been a new type of leader: *"who can establish direction and purpose, inspire motivate and empower teams around common goals and produce real improvements in clinical practice, quality and services"* (DOH 1999:52). Therefore the specific demand for leadership in nursing over recent years has been particularly strong (Scottish Government 2006).

Increasingly, therefore, nursing has seen a new emphasis on leadership within the profession, and the creation of many new leadership roles, such as those of nurse consultant and modern matron, in an attempt to meet the service change agenda (DOH HSC 1998 / 161, DOH 2003a). For the NHS, and particularly for nursing which has traditionally thrived on hierarchical structures, this new emphasis and these newly created leadership roles and desired behaviours, in line with policy direction, require a difference in style and approach in terms of leadership (SEHD 2005, 2005c). This is away from structural and hierarchical organisations and roles to more transformational, network, and clinical skills-based approaches, and to organisations which are more facilitatory, transformational and holistic in style. In recent years nursing shortages and anticipated increase in demand for nursing services, as well as the importance of nurses' job satisfaction in quality of patient care, have also brought increased interest in discovering ways to enhance job satisfaction and improve nurse retention. The culture of a healthcare organisation

can be a powerful attribute that affects nurses' work environment (Gifford, zammuto, Goodman and Hill 2002). Building a constructive organisational culture may enhance employee satisfaction and create a positive work environment, where staff feel empowered and able to approach tasks in ways that encourage personal satisfaction and meet organisational goals.

In the past, reforms have had marked changes on the structure and management of services across the NHS, which have had particular effects on nursing. These have included: reforms focusing largely on outputs linked to reducing risk, rather than quality of care; increased emphasis on management (Griffiths Report DOH 1983, Hewison and Griffiths 2004, Hewison 2004a) and the introduction of 'hybrid' or dual models of organising and managing healthcare which have been reported to have affected structures and processes and how nurses in particular carry out their roles (Hewison and Griffiths 2004, Hewison 2004a, Stanley 2006, Naughton and Nolan 1998, Christian and Norman 1998, Reed and Kent 1997).

Discussions in general relating to nurse leadership have taken place for some time on topics such as empowerment, management, gender bias, political issues, organisational structures and relations to medicine. A wealth of literature exists (although lacking empirical evidence) that discusses and describes the role and nature of nursing leadership (Scott 1987, Antrobus and Kitson 1999, Salvage 1987, Wedderburn-Tate 1999, Antrobus 2003). Whilst nurses generally have the majority of patient contact, historically they have not had any level of significant power in policy making terms, and nursing particularly, as a profession, has been caught up in issues stemming from gender stereotyping, medical dominance and inadequate professional leadership (Bishop 2009). Therefore, despite being the largest professional group in the NHS, a number of these issues have dominated the literature. Reasons cited for this are many and complex, ranging from nurses only being interested in clinical agendas, with limited knowledge and interest in broader issues, to views that nurses consider managers and policy makers as divorced from

the clinical reality of service provision. Many debates allude to the lack of leadership and management within, and at the top of the profession, and to a lack of leadership structures and roles. In summary these discussions have largely related to:

- The perceived status of the profession (Etzioni 1969).
- Leadership, management, direction and development (Fatchett 1994, 1998, Salvage 1990).
- A perceived failure to achieve control over their practice with autonomy and power clearly circumscribed by managerial and medical hierarchies (Perry and Jolley 1991, Robinson 1991, 1993).
- An inability of nursing to utilise its importance to any political advantage and a general lack of political awareness (Clay 1987, Klein 2001, Dingwall, Rafferty and Webster 1991, Clifford 2000, Hennessy and Spurgeon 2000, Hannigan and Burnard 2000).
- A lack of involvement in policy development and implementation (Robinson 1991, Robinson, Gray and Elkan 1992, Maslin-Prothero 1998, Hennessy and Spurgeon 2000, Antrobus 2003, Masterson and Maslin-Prothero 1999).
- Problems around management, particularly related to hierarchy and lack of education preparation in certain areas, such as political influencing and policy development (Robinson and Strong 1987).
- Nursing development never traditionally being considered as mainstream.
- Managers struggling in trying to continue to deliver baseline services, respond to increasing demands on the system and to meeting the government's new agenda.
- The general hierarchical structure within nursing which, unlike the rest of the NHS system, has not changed since its inception.
- Little separation or understanding of the differences and expectations of leadership, or management roles and functions. Leadership has always been seen as one of the functions of management, and both these functions have

usually been incorporated within one management role. Traditionally therefore, managers have been expected to manage the service and to lead service development, which has caused overload and unrealistic expectations (Hunter 1992), and the NHS has often then been disappointed with what these roles have achieved.

- Historically a lack of leadership development (Girvin 1996, Jasper 2002, Macpherson 1991, Hempstead 1992, Robinson and Strong 1987).

As this study will show, the new healthcare agenda has offered new opportunities for nursing to regain and develop some new professional ground. Policies set out a new vision for nursing and midwifery, providing strategic direction, integration and action within the wider modernisation and development agenda. This will give the promise of new roles, increased autonomy, authority and leadership and greater equality with other members of the healthcare team (DOH 2003, 1993, 1993a, 1999, SEHD 2001, SEHD: HDL 2001a, 2001b, 2001c, 2001d, 2003a, 2006).

Currently, within the NHS, questions have started to be asked about the appropriateness and effectiveness of management. A considerable amount hinges on achieving the new agenda and the government has indicated this is as much about changing behaviour as it is about structures. Crucially, it is about ensuring someone is responsible to see that change happens, an approach not focused on in the past. In particular this has given rise to the gradual acceptance that changes need to be made to existing hierarchies and structures within nursing, and the need for strong professional leadership at national, regional and local levels to drive not only change, but also the development of the profession. Some have attempted to depict future models of healthcare and their impact on nursing (Warner, Longley, Gould and Picek 1998, Oulton 1999, Kitson 2001). All include the need for strong leadership and dimensions highlighted as particularly pertinent are the modernisation of nursing, public involvement, the modernisation of education and democratising knowledge or evidence.

In summary, changes set out call for major transformation across the NHS, with a change in traditional structures, systems, roles and ways of working. The NHS of the future is based on partnership working and collaboration, the importance of and relationship between policy and practice, clearly defined roles, effective leadership, and clarity of aims and outcomes. Innovation and change are set to be integral components in the development and delivery of healthcare. This study will explore whether there should be increased emphasis on the need to change behaviour and how we respond in terms of leadership and management in the NHS to achieve its goals. This has largely been articulated as: delegating power and management to local levels; by working across boundaries in partnership; by blurring roles and strengthening leadership skills in a 'new way'; and via a model that reflects and recognises the complexities of today's health system which builds on 'new thinking', reflecting, empowering, learning organisations, and the creation of modern and different roles (BHBC 2007). Nurses will remain a crucial element in the wider development of the future post devolution healthcare system. However it is clear that more of the same is not going to work and different approaches are needed (SEHD 2005, 2005a). Effective management and leadership are critical if efficient implementation and change are to occur. If nurses are to have a significant impact on the development of services and care in the NHS understanding the nature of leadership and how this actually plays out in practice is crucial. In the NHS each change, merger or organisational restructure has important effects on organisational culture. Historically however, initiatives always appear to be launched in advance of an explicit consideration of the management or leadership style required to support them (Edmondson 2008).

Leadership is therefore studied here because it is significant to organisational development, wellbeing, effectiveness and quality. It is generally accepted that there is a strong conceptual link between influence and effective leadership (Bass 1990, Northouse 2001, Yukl 2002). Management studies reveal that leadership efficiently integrates and coordinates division of labour across the organisation

through influencing employee attitudes and behaviours (Ford and Randolph 1992). In particular, transformational leadership is linked to vision fulfilment, strategy execution, commitment building, employee empowerment and culture change (Yukl 1998: 324 - 438). We know leadership is a key element in successful change, and change enables (and can create) culture change. It appears the three are interconnected, and possibly that one is affected by the other. Current experience suggests that organisations in practice may take a simplistic or limited view of the connections between structures, leadership, culture and climate and therefore of their overall ability to implement change. Links have also been established in the literature between the culture of organisations and leadership skills, roles and behaviours (Alimo-Metcalfe and Alban-Metcalfe 2003, 2002, Storey, 2004, Schein, 1985, Mannion, Davies and Marshall 2005).

Despite the increasing emphasis on the importance of culture and climate, leadership roles and behaviours in establishing change in the NHS, and the key leadership roles and expectations developed and placed on nursing over the last decade, very little research on the nature of these phenomena, behaviours and links, or on their relationship in practice has taken place in the NHS. This thesis is a new empirical study which reviews the evidence concerning the development of leadership in practice within the NHS and, given that nurses occupy a pivotal role, it focuses particularly on nursing. The view here is that leadership is impacted by the organisational environment (Selznick 1952, Perrow 1967, Tichy and Devanna 1986, Alban-Metcalfe and Alimo-Metcalfe 2007, Alimo-Metcalfe *et al.*2007a Strang 2005) and it has been highlighted that too much emphasis on leadership without an equal concern for transforming the organisation, environment, nursing and other health personnels' work, may result in leadership being added to the list of transient management 'fads' which have characterised health care in recent years (Hewison and Griffiths 2004). The purpose of this thesis therefore, is to explore the relationship between leadership and leadership behaviours in nursing and their relationship to the NHS as a whole, and to contribute to the understanding of

leadership in practice within the healthcare setting. A more detailed explanation of these themes is provided in chapter two. In exploring these questions the focus will be on conducting empirical research through the collection, analysis and interpretation of findings of the collective views of a range of health professionals in NHS Scotland. By way of setting the scene for the study, the next chapter provides a review of current literature and evidence in relation to leadership and culture, providing a basis for the proposed research.

Chapter Two

Reviewing the literature 1990-2006

The topic of leadership has attracted considerable research and discussion about characteristics and types of leadership, and whether leaders are born or made. However, considerably less is known about leadership characteristics, styles and behaviours in practice, and how organisational factors, particularly structure, culture and climate, may or may not influence leadership behaviour.

The goals of this literature review therefore were to: extend knowledge and understanding of existing theory in relation to leadership and organisational culture, to review and consider research already conducted in relation to these areas and other relevant contextual factors, particularly focusing on the NHS and nursing. The review considered literature published from 1990-2006. The nature of the review process is that a specific time period needs to be selected in order to keep the majority of the data retrieved manageable whilst also ensuring that as much relevant data as possible is captured. Having become familiar with the literature base it became apparent that the majority of relevant empirical work was published from 1990 onwards, although the majority of underpinning theoretical study was done much earlier during the 1970s and 1980s. Within this study the consideration of context is relevant. Significant structural reform and managerial changes took place within the NHS in the mid 1980's. These changes are captured in the literature published in the 1990's, following the introduction of general management when consideration started to be given to the study of management and leadership and when the knowledge base started to emerge. For these reasons the dates 1990 - 2006 were selected as parameters for the literature search and form the focus of this review section.

A considerable number of studies or discussions conducted in this area appear in the grey literature. It is possible therefore that for this reason and in selecting these dates, there may be other areas of study of which the researcher was not aware of. The elements of leadership, leadership behaviour and organisational culture have been studied as subjects in their own right in earlier literature but have largely not been studied as interrelated factors, thus presenting a gap in existing literature. The purpose of this thesis is to consider these elements together and the relationship between them. Therefore in order to capture the scope of study, the initial search terms used were broad.

The research component of this thesis began in 2006 so the literature review covers literature up to this point. A considerable number of papers have been published within this area of research since 2006, and these are integrated and commented on in full within the discussion chapter

The search conducted consisted of four inter-related components, illustrated below and on pages 36 and 37. These were: a search of key databases, a search of relevant journals, reference lists in published papers and policy reports, and a review of other material and grey literature.

Search of the literature 1990-2006

Search of key databases

The following standard and specialist databases were searched for English language papers using the key words: *'leadership theory', 'leadership in healthcare', 'leadership in nursing', 'clinical leadership' 'organisational culture', 'organisational culture and healthcare', 'organisational culture, leadership and nursing'*:

Cochrane library

Medline

CINAHL

Health Management Information Consortium (HMIC)

Health Management online via the Knowledge Network

British Nursing Index

Emerald

EMBASE

OVID

Web of Science

Psychi-info

Pub-med

Science Direct

Applied Social Science Index and Abstracts (ASSIA)

Zetoc

EBSCOhost

Key journals

Contents tables of a selection of relevant management and nursing journals for the period were searched. These included, Leadership Quarterly, Journal of Nursing Management, Journal of Nursing Administration, Leadership and Organisational Development Journal, and Health Service Journal.

Search of reference lists of published papers and policy documents

The reference lists of retrieved papers and relevant policy papers were searched.

Review of other material including grey literature

Other material not retrieved by the searches described above was traced using a range of strategies. These included searches of several websites of government bodies and professional organisations such as the Royal College of Nursing (RCN), Community Practitioners and Health Visitors Association (CPHVA), Kings Fund and

reviews of oral presentations given at conferences. Reviews and searches of various management and business schools were also conducted including those of National Leadership Centres for Health Planning and Management, NHS Leadership Centre, Centre for Health Planning and Management University of Keele, The Academy of Management, Warwick and Aston Business Schools, Cranfield and Henley Management Colleges.

Several factors made reviewing the literature on these topic areas particularly difficult:

- Many institutes for policy research attached to various universities have produced papers or 'working documents' on leadership or culture or research commissioned by the Department of Health (DOH). Much of this work has not been published and is therefore not available via searching standard or specialist data bases.
- Various establishments and independent bodies have been set up in recent years specialising in leadership research within organisations. Again, much of this work is not available via traditional routes but is very relevant to this study.
- The devolution of responsibility for health services in the four UK countries in 1999 means that some of the official reports do not apply to every country, although they are part of the NHS policy context as a whole.
- Within the published literature a division exists between organisational literature, academic leadership theory and leadership which takes place in practice within organisations, particularly that of the public sector. This makes systematic searches very difficult.

However the combination of empirical papers, policy documents and papers and research from practice have led to a thorough and integrated approach to reviewing the literature and evidence available across a number of spheres. This chapter therefore reviews and considers the theory, debates and research published, and /

or available in relation to leadership and culture prior to the empirical work reported later. The review has been divided into three parts. Part one considers literature in relation to leadership and leadership development, part two considers literature in relation to organisational culture, and part three integrates the two bodies of literature, isolating key themes, debates and research aims for this study.

Part One

Exploring leadership

Introduction and overview

In reviewing approaches to the study of leadership debates appear to have been divided between characteristics, styles and situational factors, with very little work, until latterly considering the importance and links between all three. Most studies have originated from the USA and have been based on studies of 'far' leadership and on evidence from the corporate sector (Alban-Metcalfe 2004, Alimo-Metcalfe and Alban-Metcalfe 2006). It appears that little detail is known in the UK public sector about leadership roles, styles or behaviours, how leadership roles fit into organisations, or on the role context and culture may play in relation to leadership. Despite rhetoric to the contrary, considerably less is known about any of these factors in the NHS.

The nature of leadership, what constitutes leadership, and thus the associated critical issues in leadership have changed significantly over time. Building on the work done to understand leadership, the first part of this literature review:

- Reviews definitions and differences between leadership and management
- Examines approaches to the study of leadership and mainstream leadership theory
- Discusses some of the current debates
- Provides a summary and critical review of key empirical work
- Highlights other relevant key concepts for consideration
- Attempts to isolate relevant arguments and key areas

In reviewing the literature it is important to recognise that the diversity and complexity of the relevant literature make it difficult to organise, and there is no

single way of classifying the literature which captures all of the important distinctions. Most leadership theories emphasise one category more than the others or as the primary basis for explaining leadership. There is no shortage of literature on both models and theories of leadership, however relatively few models and theories have dominated the literature.

Definitions of leadership

Leadership has been defined in different ways at different times and certain models have achieved popularity at different stages, but most definitions share the assumption that it involves an influence process concerned with facilitating the performance of a collective task, and in which a person steers members of a group towards a goal. Otherwise, definitions differ in many respects, such as who exerts the influence, the intended beneficiary of the influence, the manner in which the influence is exerted, and the outcome of the influence attempt (Yukl 2002). These tend to reflect current issues and concerns, and key changes in the environment, within society, and within the environments organisations have to operate in, such as the faster pace, deregulation, uncertainty, higher expectations and structural and cultural changes in organisations themselves. Despite the multitude of ways that leadership has been conceptualised, several components can be identified as central to the phenomenon of leadership: *"leadership is a process; leadership involves influence; leadership occurs within a group context and leadership involves goal attainment"* (Northouse 1997:3).

Based on these components the following definition appears to collectively reflect this thinking: *"leadership is a process whereby an individual influences a group of individuals to achieve a common goal"* (Northouse 1997:3). Defining leadership as a process means that it is not a trait or characteristic that resides in the leader, but an ongoing process that occurs between the leader and his or her followers. The process implies that a leader affects and is affected by followers. It emphasises that leadership is not a linear one-way event but an interactive one. However,

definitions used appear to depend solely on the perspective adopted, for example in adopting a personality perspective *"leadership is a combination of special traits or characteristics that individuals possess and that enable them to induce another to accomplish tasks or 'an act or behaviour"*(Northouse 1997:2).

A major controversy in the literature appears to involve the issue of whether leadership should be viewed as a specialised role or as a shared influence process. In one, all groups have a role that includes leadership with some responsibilities and functions delegated to one lead person. Researchers who view leadership as a specialised role have paid more attention to attributes and traits, whereas those who view it as a group interactive process are likely to pay more attention to followers and group processes as a whole. Some definitions appear more useful than others but there is no single correct definition and generally there has been an ambiguity in the concept, a tendency to overlap it with management and a lack of recognition of the possible effects or role context has to play. It seems appropriate to use the various conceptions of leadership as a source of different perspectives on a complex, multifaceted phenomenon. Within the research conducted, the operational definition of leadership depends to a great extent on the purpose of the researcher (Yukl 2002). It is therefore perhaps important at the start of any study to take a broad definition which takes into account several things that determine the success of a collective effort by members of a group or organisation to accomplish meaningful tasks. The following definition is used by Yukl (2002:7):

"Leadership is the process of influencing others to understand and agree about what needs to be done and how it can be done effectively, and the process of facilitating individual and collective efforts to accomplish the shared objectives."

This definition includes efforts not only to influence and facilitate the current work of the group or organisation but also to ensure that it is prepared to meet future challenges and for this reason was initially thought the most relevant for this study.

Leadership and management, defining the differences

In a review of the literature, McCartney and Campbell (2006:190) noted that the problem of semantics was one of the major entanglements in the 'management theory jungle', particularly with respect to the definitions of the commonly used terms leadership and management. They highlight that 'leadership, often made synonymous with management by some, is analytically separated by others,' and despite this, some years later the debate still continues. One perspective is that leadership and management are distinct skill sets which differ from each other to such an extent that they are unlikely to co-exist in a single individual (Zalesnik 1977). Zalesnik's (1977:10) definitions say for example, that leadership and management 'differ in motivation, personal history and in how they think and act.' Hickman (1990) supports this view and highlights the tension between the two.

An alternative view of management and leadership, is that one construct is a subset of the other, such that one individual could possess both leadership and management skills (McCartney and Campbell 2006:191, Koontz 1964, Shriberg, Shriberg and Kumari 2005). Bennis and Nanus (1985:21) in contrast, viewed leadership as the more all-embracing concept of the two and presented leadership as the preferred alternative to management. For example, they coined the now well known phrase suggesting that 'managers are people who do things right' and leaders are 'people who do the right things'. Their position is supported in more recent writings, in cases in which management skills are downplayed, with statements referring to people wanting to be led rather than managed (Shelton and Darling 2001:265). Some leaders, particularly in the NHS, are leaders but are in management posts and some definitions tend to suggest that leadership and management are the same thing or closely related, which they are not (Kotter 1990). While Storey (2004) demonstrates a wealth of literature debating this area, a useful clarification is provided by Kotter (1990:6) who lists four similar

components of both: creating an agenda; developing a human network for achieving the agenda; execution; and outcomes. He also defines the differences. The core of modern management centres around: planning and budgeting; organising and staffing; controlling and problem solving and most importantly, producing consistency and order (Kotter 1990). Leadership is cited as very different - producing change and movement. Kotter outlines that leadership within a complex organisation achieves its functions through three sub processes: establishing direction; aligning people and by motivating and inspiring.

Despite the differences, there is still the belief that although different, leadership and management are complementary skill sets and both are necessary for executive success (Kotter 1990). In line with this thinking, it has been claimed that it is the person's ability to accept, embrace, and enact the paradoxical skills of management and leadership that distinguishes successful individuals from high-potential individuals who fail (McCartney and Campbell 2006:191, Abramson 1997). Distinctions in the definitions of the two persist in the current literature. As highlighted by McCartney and Campbell (2006) principals of management textbooks generally define management as a series of activities (one of which is leading) that are performed for the good of an organisation. Management is then defined: *"as a set of activities.... directed at an organisation's resources with the aim of achieving organisational goals in an efficient and effective manner"* (McCartney and Campbell 2006:191). In contrast definitions of leadership tend to focus on the interpersonal relationships that exist between the leader and the follower or the group of followers.

Given the number of perspectives, it appears that the debates concerning whether leadership and management skills are distinct interpersonally or whether they can coexist interpersonally has not yet been fully resolved (McCartney and Campbell 2006). McCartney's and Campbell's (2006) broad statement that a person could be a manager, a leader, both, or neither provides an inclusive framework for

addressing the controversy concerning leadership and management. In McCartney and Campbell's study and debate, they draw on Daft's work (2003), but the model created does not classify individuals as being either managers or leaders, rather as having various combinations of management or leadership skills. It further assumes that both leadership and management skills are necessary in varying degrees in order to be successful, which makes sense in practice but has not been explored empirically.

Historically there has been no agreed view in the literature on competencies regarding leadership and management, on what these are, and what each should do. This is very difficult to achieve, as thoughts and theories of leadership change over time, and depend on roles and how functions are conceptualised. This is important since until recently there has been no agreed statement in the NHS. Latterly in the literature these differences between leadership and management have been seen in the complementary (but different) models of transformational and transactional leadership (Bass 1985, 1990, Bass and Avolio 1995). The management, or transactional, model places emphasis on organising and planning the use of resources, 'fixing problems' that emerge, and monitoring the outcome of activities directed at achieving predictable outcomes and pre determined objectives. It relies on transactions between a manager and his or her member of staff in which rewards or sanctions are exchanged for performance. Whereas leadership, or transformational leadership, *"goes beyond management, and is about creating new scenarios and visions, challenging the status quo, initiating new approaches, and exciting the creative and emotional drive in individuals, to give beyond the ordinary to deliver the exceptional"* (Bass and Avolio 1996:67).

It has been argued more recently that transformational leadership is being equated with leadership per se, and transactional leadership with relatively rigid management (Alimo-Metcalfe and Alban-Metcalfe 2002). Boaden (2006) highlights that this distinction appears to have been adopted by the NHS, which argues that

both aspects are needed within single individuals: *"we need leadership in setting out vision and working with and through people to achieve it. We need excellent management in systematic and tested approaches to secure delivery and improvement. Many people of course take on both roles"* (DOH 2002 in Boaden 2006:7). However, specific and separate leadership roles have also been created.

In the main however despite some authors pursuing the notion that these two different aspects of leadership require different psychological types, (Zaleznik 1977), and as pointed out by Boaden (2006:7), the view of the NHS is that leadership is everyones' job (NHS Modernisation Agency 2003). Another view on the same issue, also highlighted by Boaden (2006) describes splitting jobs into 'management' and 'leadership' components suggesting that leadership elements may be regarded as discretionary (i.e. a matter of choice) among senior managers. The distinction is described as being relevant when there are many conflicting priorities, when it is argued the choices made will impact on the performance of the organisation.

Rather than seeking to establish distinctions between leaders and managers the two can be explained jointly using the same processes and models (Yukl 2002). The view that both leaders and mangers employ a mix of leadership and managerial behaviours initially appears realistic, (and is consistent with recent literature around definitions of clinical leadership), so that they must combine the necessary skills to direct day to day affairs effectively (a role traditionally associated with management) while at the same time anticipating and managing change (leader's main role).

Approaches to the study of leadership

The study of leadership appears to have passed through four distinct phases: the 'great man' or 'trait' theories of the 1930-1950s; behavioural theories of the 1950-

1960's; situational and contingency theories of the 1960-1970s to the visionary, charismatic or transformational theories of the 1980-1990s.

The 'Great Man' or Trait approach

This approach also referred to as the 'great man' analyses the attributes of individual leaders (for reviews see Alimo-Metcalfe and Alban-Metcalfe 2002a, Northouse 2001, Wright 1996, Hunt 1996, Rosenbach and Taylor 1993). The approach was based on thoughts that what differentiated leaders from non-leaders or followers, was their personal characteristics or traits. Leadership therefore was attributed to the possession of characteristics such as energy or intelligence which people are born with. It was proposed that these characteristics could be used to predict effectiveness in different situations. Two reviews of the literature by Stogdill in 1948 and Mann in 1959 concluded that there were no consistent findings in relation to personality characteristics that differentiated leaders from non-leaders, or greater effectiveness from less effectiveness. Results led Stogdill (1948) to conclude that the qualities, characteristics, and skills that a leader needs to possess are to a large extent, determined by the demands of the situation in which they have to function. However he also wrote that while both personality and situational factors are involved, a number of personal characteristics could be associated with being a leader such as: a drive for responsibility and task completion, originality, self confidence, a sense of personal identity, and the ability to influence others behaviour and to structure social interactions (Wright 1996). It was the combination of characteristics that was considered important and the behaviours adopted by leaders in different situations which was considered to contribute to effectiveness in a leadership role (Alimo-Metcalfe and Alban-Metcalfe 2002a). Research then focused on how leaders behaved and on identifying activities which influence others behaviour. One of the strengths of this approach is that it focused on the leader component of leadership. However it did not consider the effect of situational factors on leaders or leadership.

Behavioural approach

Focus then centred on the behaviour of individuals thought to be influential in changing the actions of followers, and leadership research concentrated on identifying activities which influence others' behaviour. Behaviours were described as the leadership or managerial style adopted by the leader, behaviour by which individuals could be measured. Alimo-Metcalfe and Alban-Metcalfe (2002a) refers to in excess of thirty different models which she summarises as four styles: concern for task (also called task orientated or production centred), concern for people (also called person orientated or employee centred), directive leadership (also called authoritarian or autocratic) and participative (also called democratic). Alimo-Metcalfe and Alban-Metcalfe (2002a) reviews work which became a key focus in drawing distinction between managers who share decision making (democratic) with those who use their authority to make their decisions. It proposed that leadership behaviour could be viewed along a single style continuum. One end represented an autocratic style the other delegating responsibility to the individual they are managing with various modifications of style represented between the two. Alimo-Metcalfe cites this work as proving very influential in the literature influencing subsequent research and management development programmes. Additional research however noted that whilst individuals who had managers with a predominantly participative style appeared to experience higher levels of job satisfaction than those individuals managed by more autocratic managers, it was not necessarily associated with also achieving higher levels of performance (Fleishman and Harris 1962, Wright 1996, Stogdill 1974, Blake and Mouton 1964, Bass 1990, Blake and McCanse 1991, Alimo-Metcalfe 1998).

Two important dimensions of leadership behaviour are cited as contributing to leadership effectiveness: consideration (employee centred or concern for people or relationships), and secondly task centred and behaviours defining activities (Alimo-Metcalfe and Alban-Metcalfe 2002a, Blake and Mouton 1964). These two dimensions were independent of each other so, for example, displaying a high

degree of task-focused behaviour may at times be combined with either high or low employee focused behaviours. Advocates of the behavioural approach suggested that the combination of leadership behaviours would lead to successful leadership regardless of the situation, which lacks empirical support (Alimo-Metcalfe and Alban-Metcalfe 2002a). The behavioural approach however did successfully focus on behaviour and how leaders act in different situations and developed important distinctions between task related and relationship related behaviour.

Situational and contingency theories

Study then focused on determining leadership style and in what circumstances particular behaviours should be adopted. In contrast to the 'great man' theories this theory views leadership as associated predominantly with the ability to learn a range of styles or competencies (Alimo-Metcalfe and Alban-Metcalfe 2002a). This was built on the belief that different situations require different kinds of leadership, and that effective leaders are those that are sensitive to followers' needs and adapt their style to the demands of different situations. Following this, Hersey and Blanchard's situational leadership model was devised assessing leadership style and followers' developmental level (Blanchard, Zigarmi and Nelson 1993). Leadership style was defined in terms of two dimensions: directive and supportive behaviours. Four styles were identified: directing, coaching, supporting and delegating. Followers were categorised into one of four groups in terms of two dimensions: commitment and competence, acknowledging that staff can move backward as well as forward along a developmental continuum (Alimo-Metcalfe and Alban-Metcalfe 2002a). The model specifies which leadership style is appropriate for each developmental level. Linked to this contingency theory (Fiedler 1967) suggested that leadership can only be understood in relation to the context in which it occurs. Success is achieved when there is a 'leader situation match' providing a framework for analysing styles and situations.

Hersey and Blanchard (1969) also identified another situational variable, the 'maturity of the follower', relating to two aspects: their competence and experience in a particular role; and the combination of task and behaviour (Alimo-Metcalfe and Alban-Metcalfe 2002a). Like Fiedler's model, this work provided a basis for designing some forms of leadership development although Alimo-Metcalfe and Alban-Metcalfe (2002a) point out important differences between the two models. In the contingency model Fiedler believes that leadership style is a relatively enduring characteristic of the leader, whereas Hersey and Blanchard believe that leadership style and flexibility can be developed.

Another theory, path goal theory emphasises the relationship between leadership style and the characteristics of both followers and work context (House and Dessler 1974). It is primarily concerned with the way in which leader behaviour, follower and task characteristics affect the path between follower activity and organisational goals. Four types of leadership behaviour have been studied: directive, supportive, participative and achievement orientated. Followers were seen to have preferences for relationships, structure, control and self confidence, which would determine the extent to which the follower found the leaders' behaviour acceptable. A leader should therefore choose a leadership style that is suited to subordinates' needs and task requirements.

Several literature reviews (Alimo-Metcalfe and Alban-Metcalfe 2002a, Northouse 2001, Wright 1996, Hunt 1996, Rosenbach and Taylor 1993) highlight that these approaches tend to treat followers in a collective way, i.e. as a group, and suggest the use of a single leadership style. This is in contrast to the fourth model discussed in this period: leader-member exchange (LMX) theory. This is built on recognising differences between leader and follower and emphasises relationships between them. Early studies focused on the quality of leader-follower interaction; and later studies on organisational effectiveness, in particular the positive outcomes for leaders, followers, groups and organisations of the quality of leader member

exchanges (Alimo-Metcalfe and Alban-Metcalfe 2002a). Effects of high quality leader member exchanges cited include improvements in employee turnover, performance, frequency of promotion, organisational commitment, attitudes towards projects, attention and support from the leader (Graen and Uhl-Bien 1995). Vroom-Yetton's model (1973) concentrated on subordinate's participation in decision-making and the effectiveness of such decisions, in the relationship between the amount and form of participation (Alimo-Metcalfe and Alban-Metcalfe 2002a).

Situational models have been particularly utilised in the NHS (Alimo-Metcalfe and Alban-Metcalfe 2002a, Edmonstone, Hamer and Smith 2003) because of their emphasis on the need for flexibility on the part of the leader and on their need to interact differently with staff depending on the nature of the objective or situation. However, models can be criticised in some cases for the lack of research to justify some of the assumptions made (Alimo-Metcalfe and Alban-Metcalfe 2002a). Contingency theory is supported by empirical research and has broadened understanding on the impact of situations on leaders (Northouse 2001). The theory is predictive, while recognising that not all leaders will be effective in all situations, but it does not explain fully why some styles are more effective than others.

New Paradigm models

Peters and Waterman (1982) first emphasised the role of the 'transforming leader' as the kind of person who was seen as articulating a vision for the organisation, communicating the vision by their passion and charisma and thus defining meaning for the organisation and transforming its culture (Alimo-Metcalfe and Alban-Metcalfe 2002a). Bryman (1996) described models that emerged as 'new paradigm' arguing that earlier models had focused on management of organisations in times of stability, rather than leadership which is primarily concerned with handling change. A range of models fall into this category: charismatic leadership (House 1977, Conger 1988, 1989), visionary leadership (Sashkin 1988) and

transformational leadership (Bass 1985, Bennis and Nanus 1985, Tichy and Devanna 1986). These were seen as describing a leader as someone who defines an organisation's mission and the values which support it. Therefore leaders are seen as managers of meaning, rather than solely in terms of influencing process (Bryman 1996, Alimo-Metcalfe and Alban-Metcalfe 2002a).

One of the most commonly referred to models in the literature is that developed by Bass (1985, 1998), described as 'transformational' because of his belief that the essential feature of a leader is their ability to transform followers 'to perform beyond expectations'. His model was based on differences highlighted between 'transformational' and 'transactional' leadership by Burns (1978). Bass challenged Burns' view that transformational and transactional leadership are at opposite ends of a continuum and following subsequent research (Bass and Avolio, 1990a), the two approaches were found to be independent and complementary. Transformational leaders are characterised by being able to motivate colleagues and followers to: view their work from new perspectives; be aware of their team's and organisation's vision; attain higher levels of ability and potential and look beyond their own interests toward those that will benefit the wider group or organisation (Bass, 1985).

The concept of transformational leadership places importance on interpersonal and influencing skills (Clegg 2000) and on skills such as motivating, inspiring, and facilitating others irrespective of context, although clearly local circumstances need to be taken into consideration (Kouzes and Posner 1997). The model has been used to inform the leadership development programme 'Leading Empowered Organisations' (LEO), used in the NHS, which has an emphasis on facilitating responsibility, accountability, conflict resolution, risk management and problem solving and the style is highlighted as the one to which professionals such as nurses should aspire (Burns 1978, Chambers 2002, Alimo-Metcalfe and Alban-Metcalfe 2002, 2002a).

Transformational leadership however has not been considered sufficient for effective organisations, and to be successful leadership must be accompanied by management, or 'transactional leadership' (Alimo-Metcalfe and Alban-Metcalfe 2002, 2002a). In transactional leadership the leader rewards the follower for specific behaviours and for performance that meets with the leader's approval and criticises or sanctions non-conformity or lack of achievement (Bass, 1998). In order to measure leadership behaviour, Bass developed the Full Range Leadership Model and from this developed The Multifactor Leadership Questionnaire (MLQ) (Bass and Avolio, 1990a, 1993). This has been validated for use in various countries and cultures, has been described as the most commonly used leadership instrument (Alimo-Metcalfe and Alban-Metcalfe 2002a, Bryman 1996, Carless, 1998), and has been adopted in many subsequent studies (Bass, 1998). It identified four transformational components, two transactional components and a Laissez-faire style of leadership defined as a negation of leadership, since there is an absence of any transaction and is thought to be ineffective (Bass, 1998, Alimo-Metcalfe and Alban-Metcalfe 2002a). These are illustrated below:

- ***Idealised influence***: behaviours that result in leaders being admired, respected and trusted, such that their followers wish to emulate them. Leaders are extraordinarily capable, persistent, and determined;
- ***Inspirational motivation:*** leaders motivate and inspire those around them by providing meaning, optimism and enthusiasm for a vision of a future state;
- ***Intellectual stimulation***: leaders encourage followers to question assumptions, reframe problems and approach old solutions in new ways, and to be creative and innovative.
- ***Individualised consideration***: leaders actively develop the potential of their followers by creating new opportunities for development, coaching, mentoring, and paying attention to each follower's needs and desires. They know their staff well, as a result of listening, communicating, and walking around

encouraging, rather than monitoring their efforts. Two transactional components were also identified:

- ***Contingent reward***: approved follower actions are rewarded, disproved actions are punished or sanctioned;
- ***Management by Exception*** (active) and ***Management by Exception*** (passive): corrective transactional dimensions. The former involves a monitoring of performance, and intervention when judged appropriate; the latter involves correction only when problems emerge.
- ***Laissez-faire***: a style of leadership that is an inappropriate reflection of leadership, since there is an absence of any transaction. This style is considered by Bass (1998) to be the most ineffective.

(Adapted from Alimo-Metcalfe and Alban-Metcalfe 2002a)

Subsequent study has led to a revision of the transformational components, in which the first two dimensions are combined into one (Alimo-Metcalfe and Alban-Metcalfe 2002a).

Despite favourable findings from these studies indicating the increased effectiveness of transformational leadership as opposed to transactional, it has been criticised for having poorly defined parameters (Northouse 2001), for treating leadership as a personal characteristic rather than a behaviour that can be learnt (Bryman 1992), and for being based primarily on quantitative data (Alimo-Metcalfe and Alban-Metcalfe 2002a). Despite the fact that instruments that measure transformational leadership have been validated in various countries and cultures (Bass 1997), questions have been raised as to whether they reflect the perceptions of leadership in those diverse cultures (Alimo-Metcalfe and Alban-Metcalfe, 2001). Research by Den Hartog, House and associates (1999) indicated that, while certain aspects of charismatic/transformational leadership generalise over a wide range of cultures, others do not (Alban-Metcalfe and Alimo-Metcalfe, 2000, 2000a). Hunt (1996) cites three criticisms: firstly that the MLQ was developed before other

qualitative data had been gathered on the nature of transformational leadership; secondly that the MLQ includes both descriptions of leader behaviour and outcomes of behaviours; thirdly that the individualised consideration scale contains items reminiscent of those included in previous leadership scales; and fourthly that the model gives insufficient attention to the two-way aspects of leader-follower relations. As highlighted by others (Alimo- Metcalfe and Alban-Metcalfe 2001), these criticisms of methodology can also be directed at all major models of leadership which were developed from studying white males, and then articulated as applying to people in general (Alimo-Metcalfe and Alban-Metcalfe 2001). Gronn (1995) and Bryman (1996) have also pointed out that apart from the nature of the sample, there have been differences in the method of data collection used, raising questions of reliability and validity.

Choice of sample has also been raised by Alimo-Metcalfe and Alban-Metcalfe (2001) who point out that the charismatic, visionary and transformational models were based on observations of 'distant' leaders such as chief executives, religious leaders and politicians, rather than 'close' or 'nearby' leaders such as individual line managers. They point out two important issues; Shamir (1995) has shown that 'social distance' affects notions of leadership; secondly, one of the important aspects of new paradigm models is an emphasis on the importance of followers' attitudes and feelings towards the leader and these appear to have been ignored when gathering data on leader characteristics.

Building on this notion, results of a study (Alban-Metcalfe and Alimo-Metcalfe 2000, 2000a, Alimo-Metcalfe and Alban-Metcalfe 2001) of middle/top managers in two major public sector organisations (one of which was the NHS) led to a very different model of transformational leadership from that developed in initial US transformational models. One of the key points made by Alimo-Metcalfe is that the world has changed since the majority of leadership studies were discussed. Many of the US models were developed in the late 1970s and early 1980s and Bass's

model was published in 1985, two decades ago. The point made is that we need to ask ourselves if we consider these models relevant and appropriate in the modern world and, considering the majority of studies were not carried out within the public sector, how applicable and transferable they are.

The Alimo-Metcalfe study adopted a different perspective from previous studies, and rather than basing findings on self reports or the study of distant leaders it investigated leadership from the perspectives of staff, choosing to examine 'nearby' rather than distant leadership. This was based on the thought that the characteristics of distant leaders such as chief executives are different from characteristics we identify when differentiating between a manager we have worked with who has a positive impact on our motivation, confidence and job satisfaction, and a manager who has the opposite effect. The study explored what it was about senior and middle managers/leaders with whom respondents had worked that had a positive, average, or negative impact on staff motivation and performance. Participants involved in the research were from representative samples of managers/leaders working at different levels in the NHS or local government. The methodology adopted was a grounded theory approach, using the repertory grid technique, interviews and focus groups, followed by the distribution of a questionnaire based on the themes from constructs. This elicited 2000 constructs of leadership which were then content-analysed independently. On this basis a pilot leadership questionnaire was developed and distributed to a random, stratified sample of organisations across the two sectors (NHS and local government). This sample were asked to distribute questionnaires to a suggested distribution of managers who were asked to rate their current manager or leader. Constructs from local government and NHS were combined for the content analysis but were kept separate on differing coloured paper. The final agreed groupings revealed equal distribution of NHS and government constructs in the 48 groups of constructs that emerged, with the exception of one which related to politicians within the local government. 2013 responses were received from the NHS and 1464 from local

government managers and professionals, and results reflected 14 dimensions of transformational leadership at all levels. These fell into the following areas: leading and developing others, personal qualities and leading the organisation.

These dimensions were ranked in order of importance of what staff perceived to be the characteristics of individuals who have a powerful positive impact on motivation, satisfaction, self efficacy, morale and performance. The single most important factor was 'showing genuine concern for others.' The dimensions reflected a variety of individual focused behaviours and attitudes which all relate to personal values, showing interest across a wide range of issues such as: whether they are happy at work; their environment; aspirations; coaching; and development. All related to what can be termed the more personal and human elements of leadership, rather than any heroic or charismatic factors.

Alimo-Metcalfe's study building on the work around transformational leadership contributes to the values based approach to leadership and was one of the first qualitative studies done in the public sector and NHS. It was one of the first conducted that was gender inclusive, and which also reflected ethnic and cultural backgrounds, and thus can be considered much more relevant and applicable for today's society and UK public sector organisations. What is extremely important to note is the complexity of leadership roles in the NHS; that the transactional competencies of management, while they may be important are not sufficient; and that existing US models of leadership do not encapsulate this complexity. Of particular importance is that asking followers and staff who work in the NHS how they perceive leadership presents a very different model. This model indicates that the most important prerequisite for the role of leader is what he/she can do for their staff, and that leadership is fundamentally about engaging with people as partners in developing and achieving shared vision and enabling them to lead.

The major difference between Alimo-Metcalfe's study and others is the finding that the single most important factor to emerge was 'genuine concern' for others' wellbeing. Other findings included emphasis on partnership working (internal and external), and although vision was acknowledged as an important characteristic, it was the importance of engaging people in the process that was highlighted. Approachability, accessibility, integrity and transparency of the leader, together with the importance placed on the development of leadership in others by enabling and encouraging staff were all considered particularly important. Issues around leaders as role models did emerge, but more emphasis was placed on the importance of humility, humanness and vulnerability of leaders. The overall conclusions of the study revealed leadership as much more a servant in relation to Greenleaf's earlier work (1970) than US and other models.

Recent debates

Three other theories or concepts of leadership have recently been documented: enabling and distributed leadership (Falk and Mulford 2001, Gronn 2000), and within the NHS, clinical leadership. Enabling leadership (Falk and Mulford 2001) focuses on leadership processes themselves. Leadership is not seen to be the exclusive domain of one person, but constructed as a collective approach to managing a specific set of events identified by a common purpose and vision rather than on any individual's views or vision. The notion of enabling leadership provides the basis for researchers' focus on leadership, as opposed to focusing on individual leader traits and attributes. Research into enabling leadership (Falk and Mulford 2001) identifies key qualities of interactive processes involved in leadership that foster positive learning of knowledge and identities, and so contribute to enhanced networks, relationships and collective action. These include: building internal networks, building links between internal and external networks, building shared visions, shared communications and building self confidence.

Theories of distributed leadership have represented the growing interest in the decentralisation of leadership skills and responsibilities in organisations and the new focus on sharing of power between leaders and followers (Senge *et al.* 1999, Kouses and Posner 1993). The concept has become popular in recent years as an alternative to traditional 'leader centric' models, suggesting that leadership is a property of the collective rather than the individual. Gronn (2000, 2002) describes it as 'concertive action' where the total is significantly more than the sum of its parts, whilst Spillane, Halverson and Diamond (2004:3) propose that from a distributed perspective leadership practice takes shape in the interactions of people and their situation rather than from the actions of an individual leader. This approach has much in common with process theories of leadership, (Hosking 1988, Wood 2005), and a systems perspective of organisations (Senge 1990, Wheatley 1999) offering a more inclusive view of organisational life whereby individuals, groups and teams at all levels collectively influence strategic direction. This perspective poses challenges to traditional hierarchical and bureaucratic models of organisations, shifting the focus from individual post holders to broader collective social relationships. In a review of the literature, Bennett, Wise, Woods and Harvey (2003) suggest that despite some variations in definition, distributed leadership is based on three main premises: firstly that leadership is an emergent property of a group or network of interacting individuals; secondly that there is openness to the boundaries of leadership and thirdly that varieties of expertise are distributed across the many, not the few.

Thus distributed leadership is represented as dynamic, relational, inclusive, collaborative and contextually situated. It requires a systems perspective that not only transcends organisational levels and roles but also organisational boundaries. The approach calls for the consideration and integration of context, to incorporate non-human, as well as the human aspects of the system involving quality assurance processes and risk management which shape the mode of engagement and interaction between individuals and groups. This situated nature of leadership

is viewed as constitutive of leadership practice and hence demands recognition of leaders' acts within their wider context. By considering leadership practice as both thinking and activity that emerges in the execution of leadership tasks in and through the interaction of leaders, followers and situations, (Spillane, Halverson and Diamond 2004:27), distributed leadership appears well suited to complex changing and interdependent environments such as the NHS. Questions remain however as to whether this represents reality and what actually happens in practice.

Degeling and Carr (2004) put forward the view that there are two components within the paradigm of leadership: institutional authority and the authority assigned by followers. Thus the authority and role of a leader cannot be viewed as some stand alone phenomenon or list of characteristics; it has to be grounded in the environment and is in constant need of being reconfirmed and enacted in the dynamics and performance and actions of that community or setting. This was cited as stemming from a study conducted in Australia, the UK and New Zealand where managers recognised that in order for their actions to be successful they could not wander far from the attitudes, values and beliefs of clinical staff. Hewison and Griffiths (2004:470) advocate a new form of leadership as a shared activity. It is about 'serving' not 'steering'; thus emphasising the view that leadership is not a position in the hierarchy but a process that occurs throughout the organisation. Leadership is based on values and is shared throughout the organisation and with the community. This appears the approach increasingly being recommended for the NHS:

"The complexity of the NHS will make it true that leadership will have to be a system involving the co-ordinated engines of a number of top level people who should act as a team, if not in unison, at least in co-ordination to get aims accomplished." (Berwick, Ham and Smith 2003:1422)

Consequently, current prescriptions for leadership therefore involve a large number of people and stakeholders, regarding it as everyone's responsibility within an organisation and beyond. However, as discussed by Hewison and Griffiths (2004:470), when the content of many nurse leadership and other leadership programmes is considered, the emphasis on individual competencies and abilities could be regarded as being in conflict with this approach and 'new leadership'.

As pointed out by Edmonstone (2008), clinical leadership has existed in the NHS since its inception and has always played an important role in service development and change. As with leadership generally, the notion of clinical leadership is a contested one and therefore seeking a consensual definition is difficult. Clinical leadership is about facilitating evidence based practice and improved patient outcomes through local care. It is therefore about more effective delivery of healthcare at the front line (Edmonstone 2008). It is argued that the concept of clinical leadership is a viable and important one, and in reality clinical leadership must involve and blend effective management in the conventional sense, with skills in transformational change, in order to make a real difference to healthcare delivery (Millward and Bryan 2005). Millward and Bryan emphasise the need to manage the relationship between health care, healthcare professionals, organisations and service users. Clinical leadership is considered to fuse managerial and clinical responsibilities with roles existing at critical junctures in an organisation. That is, the role has a dual focus to both front line clinical staff and senior managers (including executives), with the responsibility to integrate effective management with high quality care (Firth-Cozens and Mowbray 2001).

From a nursing perspective Malby (1998) has questioned whether the term 'clinical leadership' simply refers to anyone in a clinical role who exercises leadership, or whether it is a job title. She concluded that clinical leaders were simply leaders with a clinical background. Other work on this topic (Edmonstone 2005:295) agreed partly with Malby's conclusions suggesting that clinical leadership was

'leadership by clinicians of clinicians'. Clinicians were defined as front line healthcare professionals (doctors, nurses and allied health professionals) who interacted with patients, and this definition was therefore inclusive of all disciplines. Clinical leaders were defined as all those who retained some clinical role, but who also played a significant part in strategic planning, operational management and collaborative working with colleagues in their own and other clinical professions, with managers, and professionals in other agencies (Edmonstone 2005). The definition excluded those clinicians who had become full-time general managers. Edmonstone (2005) describes clinical leaders that: use persuasion rather than hierarchical power; prefer an approach to change which is evidence based and planned; feel more comfortable with a reflective and developmental approach to health care rather than a technical-rational one.

In terms of differences and similarities with differing leadership models and associated styles, the characteristics isolated above appear not in any way dissimilar to those of transformational leadership and therefore perhaps the only difference between leadership and clinical leadership is that highlighted by Malby in her definition. What is important for the NHS is to perhaps compare and contrast clinical leadership with healthcare managerial leadership as highlighted by Edmonstone (2005). According to Edmonstone (2008), historically managerial leadership in healthcare has had a corporate or macro focus on the overall needs of the organisation, with managers appointed through competition and selection and operating within set policies and procedures in order to achieve targets. Managerial leaders' ability to influence others therefore is usually founded on their positional power or their role and status within the managerial hierarchy (Edmonstone 2008). Clinical leadership by contrast primarily focuses on the patient, client group or service, with leaders appointed by managers or elected by their professional peers. According to Edmonstone (2008) clinicians are trained to think in quite a specific way with a strong emphasis on individual responsibility. For clinical leaders there is a need for them to have the respect of their colleagues with whom they typically

have a collegiate rather than a hierarchical relationship, with an emphasis on achieving change through debate, persuasion and negotiation (Edmonstone 2008:292). They are therefore accountable to both management and formally or informally to their peers. They may use the positional power associated with their role but their influence lies in their personal power which is based on their perceived credibility, integrity and trust fitting closely with factors and characteristics associated with transformational leadership.

Braithwaite (2004) comments that work considering the role of clinical managers has tended to consist of reflective or descriptive accounts of how clinicians/managers should manage, rather than how they actually do manage in practice. He comments on the lack of empirically grounded models and studies, stating that a great deal are anecdotal and opinion based. This is particularly in relation to characteristics and behaviours of managers and how these may relate to interactions and outcomes with staff.

Braithwaite's 2004 paper therefore seeks to address this by studying managers in practice and presents an analytical account and a conceptual model based on the behaviours of hospital clinical managers. The study draws on data from three studies and methodological sources (Braithwaite *et al.* 2004a); participant ethnography, focus groups and non-participant observation. Data were analysed using content analysis tools. Behaviours were categorised into five modes of operating which mainly consisted of managerial related tasks such as finance and handling complaints rather than leadership. No details are provided on how participants were recruited to any parts of the study. Nevertheless the study provides useful evidence in relation to how managers' work is conducted and alludes to a number of influencing factors such as hierarchy, power and control. It also illustrates the complexity of roles and tensions in the health service, particularly at middle manager level which is consistent with other literature in this area (Hewison 2004a). Roles are described as being difficult and complex and

suggestions are made for where development and competencies should be concentrated. Interpersonal skills are highlighted as particularly important at both individual and group levels, as are what are termed technical managerial or professional skills. The importance of communication is underlined as is the emphasis on the completion of tasks often being heavily dependent on discourse. Findings also fit with recent literature which emphasise the human and relationship elements of leadership (Alimo-Metcalfe and Alban-Metcalfe 2001). The importance of persuasion and negotiation are also discussed, working with and influencing groups, and the need for well developed political and social skills, verbal ability and the ability to cope with multiple issues. The study does not, however define the term clinical manager which therefore raises questions, given the complexity and possible cultural differences in roles, of the extent to which findings from other countries can be applied in the NHS.

Emotional intelligence

In recent years research has also illustrated the importance of taking the intelligence of feelings seriously (Goleman, Boyatzis and McKee (2002). Goleman's work draws on research conducted within organisations studying a variety of managers and indicates that leaders who excel do so, not just by using skill and competencies, but by connecting with others using emotional intelligence qualities such as empathy and self-awareness. The best leaders they feel have 'resonance', defined as a powerful ability to drive emotions in a positive direction to get results and can adapt leadership styles as the situation demands. Emotional intelligence creates and builds on positivity that unleashes the best in people. Therefore at its root the prime job of leadership is emotional which Goleman, Boyatzis and McKee (2002) refer to as 'primal,' in that making employees feel good i.e. inspired and empowered, is the job a leader should do first. Emotional intelligence therefore represents a set of core competencies for identifying, processing and managing emotions that enable leaders to cope with daily demands in a knowledgeable, approachable and supportive manner (Goleman, Boyatiz and McKee 2002). Links

can be made with transformational leadership particularly the importance of self awareness and empathy. More latterly emotional intelligence has been acknowledged in the literature as supporting nurse leadership, fostering a healthy work environment and creating inspiring relationships based on mutual trust, and particularly characteristics which emphasise qualities such as reflection, interpersonal skills, relationships and team working (Akerjordet and Severinson 2004). Emotional intelligence concerns sensing what others are feeling and handling relationships effectively; contributing a crucial set of skills for responsive nurse leadership (Goleman, Boyatiz and McKee 2002). Emotional intelligence also promotes personal growth and professional competence, determining potential for learning practical skills (Goleman 1998a, Akerjordet and Severinson 2004).

Consideration of other inter-related issues

A number of related issues have also contributed to recent debates and discussions on leadership. These include: the importance of values, the role of leadership in performance and the importance of related and responsive development programmes. Character is an aspect of leadership that has received considerable attention and has been described as one of the most important attributes of leadership and as the foundation for transformational leadership (Burns 1978). One aspect of character is a leader's honesty or integrity (Russell and Stone 2002) which like character integrity, has been named as a hallmark of successful leadership (Bennis and Thomas 2003) and a means of establishing credibility (Kouzes and Posner 2004). Ethics are also considered to be part of a person's character and closely related to integrity (Bennis and Thomas 2003, Drucker 1999, Vecchio 2003) with claims that ethics are central to leadership because of the nature of the leadership process and the need to engage followers to accomplish mutual goals (Ghosnal 2005:79). Values and core beliefs are also described as components of character as they relate to leadership (Canella, Pettigrew and Hambrick. 2001, Connor and Mackenzie-Smith 2003, Drucker 1999, Goleman

1998). According to Bennis and Thomas (2003), having a strong sense of values is one of the four characteristics of effective leaders. Russell and Stones (2002) model of servant leadership presents values and core beliefs as the key drivers of servant leadership. Values influence cognition through their impact on judgement regarding moral behaviour, then impacting on behaviour through the enactments of those judgements (Russell 2001). Values have also been related to behaviour (Russell 2001, Hambrick and Mason 1984) as many leaders consider various behavioural alternatives but reject some due to inconsistency with their personal values.

Historically there has been an ongoing debate within the management literature on how important leaders are in determining the performance of organisations. A considerable amount of work over recent years has concentrated on trying to explore and demonstrate links, particularly in relation to determining outcomes, performance or job satisfaction and the leadership styles of managers (Bass and Avolio 1996, Kozlowski, Gully, Salas and Cannon-Bowers 1996, Stewart and Barrick 2000, Morana 1987, Kivimaki and Kalimo 1994, Guo 2004, Rad and Yarmohammadian. 2006). Despite few studies being conducted in the UK or NHS, implications drawn from these studies suggest that leadership is a key variable for team functioning, one of the main reasons for success or failure of change (Katzenbach 1997, Gil, Rico, Alcover and Barrasa 2005) and that employees' job satisfaction depends upon the leadership style of managers (Rad and Yarmohammadian 2006). Guo (2004) reviews the critical role leaders' play in the organisations' goals in determining ultimate success or failure, highlighting that the single most important characteristic is passionate executive leadership. A number of reviews (Bass 1998, Gasper 1992, Lowe, Kroeck and Sivasubramaniam 1996, Patterson, Fuller, Kester and Stringer 1995) have demonstrated that transformational leadership has a strong positive relationship with objective measures of organisational productivity as well as subjective measures such as job satisfaction. Most of these studies reviewed were performed in the US. More

recently there appears a growing body of literature looking at various aspects of leadership and their relationship with performance (Moshavi, Brown and Dodd 2003), although again relatively few have been done within the UK, or within healthcare. Those studies that have been done in the UK, although not published in peer reviewed journals, are available to some extent through the grey literature, which is why it is important to consider grey literature in this area.

One such study was conducted by Aston University (commissioned by the NHS Leadership centre), exploring relationships between top management, team leadership, trust performance, immediate manager/supervisor leadership and trust performance (Borrill, West and Dawson 2005). Data were gathered during 2001 and 2002 on top management team leadership and immediate manager/supervisor leadership in five NHS trusts in England, and were linked with performance data gathered during 2003 and 2004. This involved 23,720 staff across 134 NHS Trusts, utilising two questionnaires and stratified random sampling across a number of professional groups, including nursing. The questionnaires consisted of a number of five point scales, asking staff to rate various themes. Reliability of the questionnaire was established using Cronbach's alpha. Results revealed that top management team leadership and immediate manager supervisor leadership predict the performance of trusts in a number of areas. These included higher star ratings, fewer complaints, improved clinical governance ratings, improvements within risk management and staff job satisfaction, providing support for the current emphasis on developing leadership in the NHS. Results suggest that investing in leadership development at all levels within the organisation improves organisational performance and wellbeing of NHS staff. The study included a wide ranging sample across a number of hospitals and clinical groups. It makes an important contribution, showing a positive relationship between leadership roles and outcomes. However despite establishing face validity, this was a quantitative study using a structured questionnaire with questions set by researchers. The methodology employed therefore did not allow any in depth exploration or

understanding of leaders' roles and their relation to the wider organisation, and did not allow respondents the opportunity to express what informed their opinions and answers. These therefore remain unexplored areas.

Impetus for leadership development has centred on reforming how healthcare is delivered through the redesign of services to secure better delivery, and improving overall performance in terms of care and treatment. In line with the changing climate, the Scottish Government (2005) launched a framework for leadership development within the NHS in Scotland adopting a focused approach on needs of services, teams and individuals. The Scottish Government has stressed that leadership must permeate through organisations, through all wards and teams and must support frontline leaders to deliver service improvements (SEHD 2005). In response various leadership development approaches have been employed across the NHS (DOH 2000, Hewison and Griffiths 2004) which encompass local and regional programmes, centrally funded and self financing programmes organised at national level, employer programmes where the NHS has taken local action to meet need, and independent courses funded by individuals.

Leadership development courses are said to differ from programmes. Courses are considered fragmentary and piecemeal, whereas programmes adopt a more integrated and cohesive approach in accommodating team development, personal mentoring and learning networks (Edmonstone and Western 2002). The foundation of the NHS Leadership Centre in April 2001 enabled a number of leadership development programmes previously commissioned by a variety of areas within the NHS to be brought together in an attempt to standardise approaches to leadership development (Boaden 2006:5). The publication of subsequent Leadership Frameworks and managerial codes of conduct sought to address how the NHS can create a coherent core of values and systems combined with specific national initiatives that will help managers and leaders in practical ways (DOH 2002). The work of the leadership centre was categorised into three areas: strategic

leadership, frontline leadership and building capacity (NHS Modernisation Agency 2004). All these work streams included programmes for both clinical and non clinical staff from a variety of professions. In advocating that an organisation's 'tone' is often set by the styles and behaviours of senior managers (Scottish Government 2005), the critical role of senior leaders and managers in the NHS was emphasised, together with the need to focus on programmes for these staff, in order to achieve any shift or change in practices. The Leadership Centre indicated the intention to move away from mainly focusing on providing leadership development programmes to exploring how to contribute to leadership policy, ensuring best practice at local level, promoting diversity in leadership and to research the results of effective leadership (NHS Modernisation Agency 2003).

Despite the increased profile of leadership and leadership development in the NHS many leadership programme evaluation studies (Edmonstone and Western 2002, Millward and Bryan 2005) highlight the lack of consideration towards contextual and cultural factors within these programmes. Despite a strong base of support for leadership in the literature, the number of published studies documenting the implementation and evaluation of leadership development programmes for nursing professionals is limited. While there has been extensive work on competencies of nurse leaders (Duffield, Donoghue, Pelletier and Adams 1993, Mackay 2002, Contino 2004, Carroll 2005), reviews of major online databases generate very few published reports on leadership development programmes (Edmonstone 2005, 2008).

Summary

A review of the literature, particularly conducting a chronological review reveals a number of limitations. The main one is that subsequent accounts tend to imply that previous theory has been refuted and superseded, and appear to set approaches and theories up in competition. Theories tend to be reviewed and developed in independent 'boxes'. In recent years these appear more diluted with

more attempts to integrate approaches but still do not appear in most cases to be related to or based on current organisational life or situations. Most researchers have dealt with one narrow aspect of leadership, and as a result most studies fall into distinct lines of research including research into leader traits, behaviour, power and influence and situational approaches. Three broad types of trait have been examined, physical factors, ability and personality features, such as self-confidence and dominance. This then led to research on Leadership style and behaviour, and what leaders do, to more contingency approaches to the study of leadership, the possibility that effectiveness and styles of leadership are dependent on situations and certain types of behaviour, and styles are appropriate in different situations. Contingency factors attempt to provide a theoretical justification to the idea that particular situational factors moderate a leadership style outcome. All look at relationships and styles but the styles and the 'how' differ. In some, more emphasis is on changing the situation, and in others on leadership style. In terms of organisational research, not a great deal of research has taken place and that done divides into two areas: organisational behaviour orientated to individual and small group behaviour, and organisational theory concerned with the attributes of the organisation such as structure and environment.

Confusion has existed in the literature in definitions of the phenomenon due to some extent to the number of studies and different methodologies employed. Some researchers have studied the characteristics of individual leaders; others have studied the characteristics of those who display leadership, irrespective of whether they occupy leadership positions. In the former, leadership is regarded as an independent variable, in the latter as a dependent variable. This makes assessing implications difficult. Little research has taken place on the moderators of leadership or leadership effectiveness, such as organisational culture and context or personal characteristics of leadership and their relationship to effectiveness and improved outcomes. It is important to note from whose perspective leadership is being defined or constructed and to distinguish between studies of distant and

nearby leadership. Previous models have also led to some myths: firstly that leadership was rare, secondly that it is found at the top of organisations and thirdly that it is about being superhuman (Alimo- Metcalfe and Alban-Metcalfe 2001).

Texts suggest that the last two decades have been dominated by charismatic and transformational leadership. Now it appears there is some disillusion with these. What replaces them depends on the view of what's needed and what leadership is. If it is viewed as an attributional phenomenon, searches will be directed to the social and economic climate. If it is viewed functionally, the focus will be on analysis of the kinds of issues/problems to be faced, and the kinds of solutions deemed likely to be required. In practice these two forms of analysis seem to be seen together and it is difficult to separate the ideological from the functional. For example, currently the type of leadership favoured is distributed and clinical leadership, and this appears to appeal as it seems to be in tune with the preferred cultures and structures of organisations, which lean towards empowered teams, distributed responsibility, and network forms. This illustrates that theory and models cannot be separated from organisations, ideology of the period and culture. In recent years there has been more reliance on interagency working and leadership in a more network context, and therefore on skills such as coalition building, and understanding others' perspectives.

Transformational leadership has been found to be specifically relevant to functioning in complex organisations with links to charismatic and inspirational leadership as components. The model focuses on change, recognising the need for change and change within the organisation, and to an approach to leading through committed followers. Charisma has been found to be an important element concerned with personality and behaviour, but is not enough on its own to enable transformational leadership. US models and previous theories have placed emphasis on charisma and vision and on the leader as a role model for followers. Latest research has suggested that the most important role of a leader is what they

can do for their staff, almost as a servant type model, where leadership and leaders roles are based on the needs of others (Alimo-Metcalfe and Alban-Metcalfe 2001, Greenleaf 1970). This model challenges traditional hierarchical driven models, replacing them with more democratic and learning focused approaches reflecting the stronger democratic elements organisations now require. Interestingly, within the main leadership literature Greenleaf's work often appears to have been sidelined and yet the theory based concept of serving others is probably now the central paradigm in the current literature on the subject. A key factor is also about how others/followers are engaged as partners, and links can be made here to distributed leadership. Within the NHS currently, some near and far leadership is often required in key roles, but how this functions is dependent on situational factors and factors around organisational structure and culture. Considerable literature to date sees followers as passive recipients of leadership and the leadership process, and even now the focus is on the relationship between leaders and followers versus context and the importance context plays in this, on both roles and how both leaders and followers function and operate. Effective leadership has been found to occur where there is a relationship between the external environment as well as the attributes of the individual leader, and highlights the importance of context (Falk 2003); and issues of contextual complexity apply to mission, organisations and environment, culture, structure, types of problems and types of opportunities (Van Wart 2003). In order to understand any leader's role we need to understand both the organisational context in which it exists and what the leader is expected to achieve in terms of outcomes. The roles of top managers have been found to be crucial, and links have been found between leadership styles of top managers and cultures of organisations. Implications therefore are that future research should explore leadership in the context of the wider factors and processes in organisations. In reality, questions concerning leadership, qualities and characteristics, appropriate styles, contingent conditions, transactional and transformational relations continue to confuse, overlap and prompt debate. Undoubtedly leadership is a bit about personality and the person and attributes of

individual leaders are necessary, but are not effective on their own. Context and situational factors are needed to fulfil roles and style then is dependent on circumstances, context and the environment of the time. The next part of the literature review, building on the work done to understand leadership, will explore the links, relevance and importance of organisational culture.

Part Two

The relevance of organisational culture

Introduction

In conjunction with increased focus on leadership, all recent government policies have advocated that a culture and climate of change needs to be created in the NHS, together with changes in behaviour and mindsets. This has brought into focus the need to modernise and transform values and working practices. These 'values, working practices and patterns of behaviour,' are often referred to as an organisation's 'culture', and therefore recent policy has been directed towards changing organisational culture. As well as strengthening the focus on leadership, achieving cultural transformation has also therefore been at the heart of the UK government's reform of the NHS over the last few years. The NHS modernisation plan is calling for fundamental changes in NHS culture in which the empowerment of staff is a central feature and one in which hierarchies are replaced by devolved local systems and networks.

Whilst the NHS talks about cultural change, in practice at both national and local levels, there is little clarity and consensus about the nature of the cultural change that is required, and little practical guidance available on how to deliver cultural change on the ground, how change will come about, or why such change will produce anticipated effects. It is almost assumed cultural change is a natural bi-product of many service improvement initiatives. Healthcare organisations contain considerable cultural diversity, reflecting the different professions, management and educational backgrounds of those who work within them. Traditionally they do not have a strong-shared culture, and tensions, different values and beliefs have caused considerable resistance to change. Cultural transformation has been thought more likely to emerge from direct attempts to understand and influence unwritten rules and behaviours (Mannion, Davies and Marshall 2005a). Overall

philosophies have emphasised the need to focus on the creation of 'learning organisations' (Senge 1985) defined as ones that position learning as a core characteristic, characterised by open systems thinking, team learning and improving individual capabilities. Already outlined strong links have been made between improved performance, the achievement of cultural change and leadership, leadership skills, roles and behaviours and therefore the NHS as an organisation in recent years has been asked to adopt these approaches.

Although links have been established between the culture of organisations and leadership, in the literature little if any research, particularly in the NHS has explored the nature of these links and relationships in practice. As with leadership there have been few studies looking particularly at organisational culture in healthcare and none (until very recently) specifically explores its relationship with leadership. Many studies however allude to its importance (Mackenzie 1995). A number of these consist of descriptive reviews or discuss culture by way of a bi product of other research (Porter and Mclaughlin 2006) with very few specific empirical studies. Therefore many studies relate indirectly to the subject area, but few have specifically studied the topic in detail.

Recent research that has been conducted in the NHS focuses on the relationship of culture to performance and outcomes (Scott, Mannion, Davies and Marshall 2003, Mannion, Davies and Marshall 2005a). 'High' performing organisations are said to have certain attributes, such as, promoting and valuing innovation, staff development and empowerment. The importance of leadership is considered paramount and for leadership roles to succeed and flourish that organisational culture is particularly relevant (Gerowitz 1996). According to Mannion, Davies and Marshall (2005) and Scott, Mannion, Davies and Marshall (2003) however, the notion that organisational culture can affect healthcare performance rests upon a number of assumptions one of which is that culture relates to performance, and like some of the other assumptions listed by these authors this is not supported

necessarily by evidence (Scott, Mannion, Davies and Marshall 2003a). In reality, personalities, cultures and styles are important, but context and situational factors are needed to fulfil roles, and style is often then dependent on circumstances, context and the environment of the time. Schein (1992) argues: firstly that organisational leadership and culture are intertwined and culture can aid or hinder organisational effectiveness and that leadership is the fundamental process by which organisational cultures are formed and changed, and secondly it takes strong leadership to create a useful culture and only with certain kinds of culture does one find competent leadership emerging through the organisation. The second part of this literature review therefore aims to:

- Define what is meant by the term organisational culture
- Review theories and literature on organisational culture
- Examine the extent to which organisational culture and its relationship with leadership have been studied.

An overview of organisational culture

Organisational culture is an anthropological metaphor and has its history in social anthropology describing processes of socialisation in societies through family, community, educational, religious and other institutions. Over more recent years particular relevance has been found for organisational studies, seen particularly in studies such as the Hawthorne studies, which showed links between informal social dimensions and organisational structure and performance, and how these aspects could be manipulated to affect employee effort and commitment. Continuing on from these studies, in later years a number of research studies have shown the importance of leadership in shaping organisational behaviour and performance (Schein 1985, Seliznick 1957, Mannion, Mannion, Davies and Marshall 2005, Mannion, Davies and Marshall 2005a).

The cultural literature is generally divided into two broad streams (Smircich 1983). One stream considers culture as an attribute, something an organisation 'has', and another regards culture more holistically as defining the character and experience of organisational life, 'what the organisation is' and as a way of thinking about or viewing an organisation consisting of basic assumptions, values, artefacts and creations. Organisational culture is therefore created through the social interactions of participants, termed 'culture as a metaphor' approach. Key differences between these two approaches are outlined in Table 2.1.

Table 2.1: Comparing 'culture as an attribute' and 'culture as a metaphor'

	Culture as an attribute	***Culture as a Metaphor***
Disciplinary base	Social psychology	Anthropology
Epistemological assumptions	Positivist	Phenomenological
Methodology	Nomothetic	Ideographic
Theory of cultural cohesion	Unitary culture	Co-existing subcultures
Theory of organisational order	Consensus	Conflict
Creation and transmission of culture	Formed and directed by actions of senior staff to change artefacts and espoused ideology	Reproduced by all culture members through their ongoing social interactions
Culture change agents	Senior management manipulate culture to meet corporate objectives	Managers, as well as other organisation members, seek to influence cultural direction of the organisation

Taken from Mannion, Davies and Marshall 2005a:20

Meek (1992) and Bate (1994) also argue that the various theories fall into one of two groups. In one, again culture is seen as something an organisation possesses, which can be manipulated by management (Meek 1992:99). In the other, culture is seen as a paradigm, a way of thinking about or viewing an organisation; is embedded in the organisation's history and structural relationships; and is something the organisation is (Smircich 1983:347). The former might be called the managerial view of culture, the latter the anthropological.

The distinction between these two views, as an attribute, or metaphor, has important policy implications. The view of culture as an attribute has been interpreted as meaning that culture is an independent variable and therefore can be manipulated to meet organisational objectives. Defining culture as a metaphor by contrast, means organisations are cultural systems and culture then defines organisational meaning. In recent literature Mannion, Davies and Marshall. (2005) treat organisational culture as an emergent property, considering it not as something fixed and static, but as something which all those in an organisation are constantly creating. Organisational culture is the result of continuing negotiations about values, meaning and properties between the members of an organisation and its environment (Seel 2000). By this definition culture is not controlled, instead, its main characteristics can be described and assessed in terms of their wider contribution to organisational objectives.

Definitions of organisational culture

A key methodological principle in studies of organisational culture has been to investigate organisations as mini-societies (Allaire and Firsirotu 1984; Ashkanasy and Jackson 2002) aiming to highlight participants' interpretations, evaluations and expressions of their roles within the wider context of an organisation. However, a plethora of definitions exist around organisational culture, and as with leadership these are largely dependent on the approaches and perspectives adopted (Ott

1989; Alvesson 1995; Brown 1995). Some of the thinking and focus of these are outlined in Table 2.2.

Table 2.2: Conceptions of organisational culture

Focus	***Description***
Exchange regulation	A form of control used to shape shared views with a view to reducing transaction costs.
Compass	A shared value system that provides guidance and direction.
Social glue	The shared values, beliefs, understandings and norms that bind an organisation's members into collective endeavour.
Sacred cow	Ideals and values internalised and held sacred by an organisation's members.
Management control	The manipulation of beliefs and values as a means of meeting strategic objectives.
Affect regulation	The control and management of the affective and expressive elements of organisation.
Non-order	The inherent ambiguity, uncertainty, contradiction and confusion of organisational life.
Blinders	The deep aspects that provide an unconscious guide to behaviour.
World closure	A shared view on life.
Dramaturgical domination	The manipulation of symbols and their dramatic attributes in a political context.

Abstracted from Alvesson (1995) and cited in Mannion, Davies and Marshall 2005a:17

Organisational culture is generally seen as a set of key values, assumptions, understandings and norms that is shared by members of an organisation and taught to new members as correct (Daft 2005). Mannion, Davies and Marshall (2005) focus on the metaphor of organisational culture and on that which is shared between people in organisations. For example: beliefs, values and ideologies, attitudes and norms of behaviour; routines, traditions, customs, symbols, ceremonies and rewards and meanings, narratives and sense making. According to Mannion, Davies and Marshall these shared ways of thinking and behaving help define what is acceptable within any given organisation guiding peoples' behaviour. What distinguishes one culture from another is unspoken knowledge, which local practitioners understand but are not necessarily conscious of. Culture, therefore, does not merely include the observable, but also tacit and implicit assumptions. For these reasons most recent studies around culture refer to Schein's (1985) definition, who defined organisational culture as:

> *"The pattern of shared basic assumptions – invented, discovered or developed by a given group as it learns to cope with its problems of external adaptation and internal integration – that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems."*
> *(Schein 1985)*

This therefore includes both the observable and the shared cognitive and symbolic context within which an organisation can be understood. Many authors also agree on the multilayered and complex nature of organisational culture, and Schein identified three levels which have provided an acknowledged framework for study and analysis:

Level 1 ***Artefacts*** – the most visible manifestations of culture, including its rituals, rewards and ceremonies. Artefacts are especially concerned with observable patterns of behaviour within organisations.

Level 2 ***Beliefs and values*** – espoused beliefs and values which may be used to justify particular behaviour patterns and which form the basis for choosing between alternative courses of action.

Level 3 ***Assumptions*** – the real, unspoken, largely unconscious beliefs, values and expectations held and shared by individuals; these may be signalled by artefacts that belie the espoused beliefs and values.

(Taken from Mannion, Davies and Marshall 2005a:18)

Despite these discussions and definitions, relatively little work has explored the deeper levels of culture (Scott, Mannion, Davies and Marshall 2001, Scott, Mannion, Marshall and Davies 2003a) and work on cultural change has suggested that while level one may be relatively susceptible to change, the deeper values, beliefs and assumptions may often remain unchanged with the potential to negate, or redirect change efforts (Jones and Dewing 1997; Harris and Ogbonna 2002).

Organisational culture is related to, and sometimes appears conceptually indistinct from organisational climate. Although culture and climate have much in common they are often used with unclear delineation (Schneider 1990; Denison 1996; Payne 2000; Ashkanasy and Jackson 2002; Bower 2003). Studies of culture attempt to access deeper values and assumptions, rather than surface perceptions said to be the focus of climate studies (Denison 1996, Payne 2000, Schein 2000). Organisational culture also centres on that which is shared by group members (Davies, Nutley and Mannion 2000) and is more concerned with a qualitative understanding in a particular social setting which emphasises the dynamics from which culture emerges, rather than with quantitative snapshots that compare the

climate of organisations at a given time point (Fey and Beamish 2001). Nevertheless the overlaps between the two terms are significant and some authors have suggested that variations in use of the terms represent more historical fad than substantive difference (Schneider and Reichers 1983, Fey and Beamish 2001). The term 'climate' is sometimes used by those interested in the concepts underlying organisational culture, but who have concerns about the ways in which the term has been used in the past.

One reason for the confusion and debate in the literature could be that in reality most of the few studies claiming to have studied culture in reality have assessed what could be referred to by this definition as context and climate. The literature also suggests (McCormack *et al.* 2002), that a focus on systems, processes and structures in organisations may tell us about the context in which practice takes place, but it does little to articulate the culture of a practice setting. Cultural research argues for the importance of a deep understanding of underlying assumptions. Climate research in contrast typically places a far greater emphasis on organisational member's perceptions of 'observable' practices and procedures that are closer to the surface of organisational life.

In reviewing the literature Denison (1996) outlines contrasting perspectives which supports distinctions between the two phenomena. Culture refers to the deep structure of organisations, which is rooted in the values, beliefs and assumptions held by organisational members. Meaning is established through socialisation to a variety of identity groups that converge in the workplace. Climate portrays organisational environments as being rooted in the organisations value system, but tends to present these social environments in relatively static terms, describing them in terms of a fixed set of dimensions. Thus climate is often considered as relatively temporary, subject to direct control and largely limited to those aspects of the social environment that are consciously perceived by organisational members.

Denison highlights that although both culture and climate are very different perspectives on organisational environments, it is far less clear that they examine distinct organisational phenomena. Further comparisons of other definitions of culture and climate help to support the idea that there are both differences and similarities in the phenomena under investigation in the two literatures. As Schein (1985, 1992), and Tagiuri and Litwin's (1968) definitions showed, the culture literature often focuses on how social contexts develop out of interaction, whereas the climate literature is more likely to focus on the perception of social contexts and their impact. The focus of the climate literature on the features of organisational context has often led to the conclusion that climate refers to the features rather than to the underlying context itself.

The study of organisational culture

Research has been conducted on antecedents and outcomes of organisational culture, leadership behaviour, organisational commitment, job satisfaction and employer performance, for example, work ethics (Yousef 2001), person organisation fit (Silverthorne 2004), national culture (Lok and Crawford 2004), task structure and role ambiguity (Tan 2005) and turnover (Poh 2002). Whilst leadership is not the primary focus of most of these types of studies, many indirectly relate to leadership or to leadership roles and behaviours. The literature and studies which have been undertaken, for ease can be artificially categorised under five main headings:

- Those that relate to the study and association with change management, quality and clinical governance: (Beil-Hildebrand 2002, Davies, Nutley and Mannion 2000, Walshe 2000, Mallak *et al.* 2003, Manley 2000, 2000a).
- Those primarily concerned with 'learning organisations' but which discuss climate, culture and environmental factors: (Senge 1985, Pettigrew, Ferlie and McKee 1992, Rycroft-Malone *et al.* 2002, McCormack *et al.* 2002).

- Those that study or relate to performance and outcomes (including both staff and patient satisfaction): (Scott, Mannion, Davies and Marshall 2003, Gershon 2004, Schein 1992, Clarke 2002, Miller Franco 2002).
- Those that explore and discuss the role of sub cultures: (Mannion, Davies and Marshall 2005a).
- Those that explore or relate to the roles of leaders and managers: (Gerowitz 1996, Valentino 2004, Lindholm, Sivberg and Uden 2000).

Categorising these studies is difficult as many of the variables studied overlap. However for ease of presentation studies have been classified according to their main areas of research. For the purposes of this review concentration will be on the roles of leaders and managers and the links between organisational culture and leadership specifically.

The roles of leaders and managers in shaping culture or being shaped by culture

Very few studies either in the UK or internationally have studied the actual role of leaders and managers and organisational culture and performance, bar one or two descriptive studies on what managers need to do to develop the capability of the NHS and the importance of open trust and style. Two significant studies which do discuss the role and links of managers and organisational culture have been conducted outside the UK, one Canadian (Valentino 2004) and one from Sweden (Lindholm 2000), and have particular significance.

Valentino's 2004 study examined the role of middle managers in the transmission and integration of organisational culture via managers' roles in merger. The study explores managerial/leadership roles and change management using Schein's model (1999) which proposes eight essential steps for integrating and transmitting an organisation's culture, together with Bennis (1989) four competencies of

leadership, to create a theoretical framework for discussion and to analyse data. The combined models are illustrated in Table 2.3. Bennis framework aids categorisation and records actions that create a clear set of goals, values and basic assumptions for organisations' employees. By combining these two theoretical models the study tries to illustrate how middle managers are able to 'pull' together a style of influence (Kotler 2000) to attract and energise people and create ownership to engage in the new organisation's vision for the future.

Table 2.3

Integrated framework for the transmission and integration of an organisation's culture	
Bennis's Competencies	***Schein's Steps***
1 Management of Attention	**1** Create a compelling positive vision.
2 Create a compelling vision that moves the employees beyond their present vision to a new vision.	**2** Coach and provide feedback.
3 Management of Meaning	**3** Be a positive role model.
4 Communicate the meaning of the vision to the employees.	**4** Provide opportunities for formal training.
5 Management of Trust	**5** Create in employees a sense that the organization's leaders will allow them to manage and be in control of their own personal learning process.
6 The ability of managers to demonstrate reliability or constancy, keep their word and always let the staff know where they stand.	**6** Create interdepartmental groups and cross-departmental liaisons.
7 Management of Self	**7** Provide support groups.

8 The ability of managers to make not just decisions but also collective decisions.	**8** Align the organization's reward and discipline systems with the new way of thinking and working.

Valentino:Journal of Healthcare Management November / December 2004 49:6

The aim of Valentino's study was to link the bodies of literature on organisational culture and organisational merger with a qualitative exploration of the role of the middle manager in cultural change. The study conducted interviews with middle managers, chief executives, and other staff of a recently merged healthcare organisation. No sample details or details on methodology are provided, which makes any assessment and discussion difficult and it is a study relating to change rather than leadership. The study does however provide some interesting data relating firstly to the difficult role of middle managers, secondly to the difficulties encountered around cultural change, and thirdly highlights the tension between hierarchical levels in the NHS and the difficultly this causes in attempting to create unified cultures, values and approaches. Perceived barriers to change included: trust, relationships with senior managers, feelings of isolation, hierarchies and command and control mechanisms. The point is made that these issues make it extremely difficult in practice to achieve any form of trust with staff (which relies on reliability, honesty and consistency), and are important factors related to successful leadership. It also highlights differences between what managers/leaders sometimes say and what they do, and some of the reasons for this, often saying on one hand something is very important but then in practice not demonstrating this. Two distinct management cultures are described: one at the top, as command and control, and one at the middle, described as the one having to implement the change. This makes attempts at any uniformity of culture very difficult.

Some of these factors are not a surprise and are already well documented in both the change management and the leadership literature. It does however highlight

the importance of understanding underlying assumptions to understand what needs to be changed and what kind of resistance may be encountered. The study concludes that culture is related to organisational change. Organisations that are successful reinforce basic assumptions and therefore strong organisational cultures. As long as an organisation's internal environment remains stable, and continues to experience success, organisational culture remains. However when the organisation's internal environment changes, some of those shared basic assumptions can become difficult to manage precisely because of their strength. Valentino suggests that basic assumptions seem to operate as cultural filters, making it difficult for organisational members to understand alternative ways of thinking, acting, doing or carrying on the day to day activity of the organisation. The author discusses the important role of managers, developing and translating the organisation's vision and ideas into action and change. Valentino states that leaders and managers who understand the construct of organisational culture and its potential, affect employee's willingness to identify with and become emotionally attached to the organisation's basic underlying assumptions. Through the transmission and integration of an organisation's culture, they potentially affect and contribute to the development of the employees' effective commitment.

The aim of Lindholm's 2000 study in Sweden was to explore the meaning and application of nurse managers' leadership styles within the healthcare system and a constantly changing environment. The study was conducted via 15 open ended interviews with nurse managers across three hospitals. The sample consisted mostly of executive managers, and attempted to elicit both professional intentions and actual behaviours. However, no observational study was conducted and this information was obtained via interviews only. Four leadership styles were identified, hierarchical authority, the formation of hierarchical adjustment, a career approach and the formation of a devolutional approach. These styles diverged and/or converged in an overall perspective regarding different dimensions recognised during the process of analysis. Two of these dimensions, organisational

culture and professional background, reflected prerequisites in nursing management, while leadership model strategy towards the people in control and management idea reflected the procedure of nursing management. The four types of leadership style identified during the study contained three - four nurse managers each, which in this limited group of managers represented a relatively even distribution. The leadership styles tended to be either predominantly transactional, (hierarchical) or transformational, (career approach), or a combination of both (hierarchical adjustment or devolutionary). From an overall approach, there was a marked difference showing that nurse managers who had a less unambiguous leadership style, close to either the transformational or transactional model seemed to experience fewer problems concerning acceptance, confidence and support in the exercise of their roles than managers with a composite leadership style, who were acting within the fields of both leadership models and experienced more problems with their management roles. One explanation offered by Lindholm for this is that the former possibly appeared more distinctly as leaders to their staff with clearly expressed goals directed to either nursing or the organisation. Another important discussion within the study relates to the interdependence of ethics and leadership in relation to the devolutionary approach. The significance of this was also raised by Sofarelli and Brown (1998), who stressed that models of leadership in nursing should correspond with the ethics of the profession.

The attitudes of the managers to their existing organisational culture differed among the four groups. The study made a connection between this attitude and areas within their management roles, such as the leadership model adopted, the strategy towards the top level and their management ideas. The way the nurse managers conducted themselves in their existing organisational culture seemed to influence their experienced degree of resistance and or support received from the top level and other professional groups. The management ideas of the nurse managers also varied among the four groups of leadership styles ranging from

control to self management (from hierarchical to devolutionary), and was discussed in the hierarchical adjustment group as ranging from those wanting to give up control and trust lower levels of staff to those who needed and wanted to retain more control. Lindholm's study does not articulate whether this is down to lack of experience although details of the overall sample indicate all participants were experienced senior nurses. It makes important suggestions about certain styles of character being more appropriate for leadership roles than others, which, anecdotally, has not been explored for practice within the NHS until fairly recently. Some of these results correlate with previous debate, (Porter O Grady 1994) and with models of what is referred to as 'shared governance': a transitional structural model that can facilitate ownership and accountability at all levels of the organisation by involving groups of staff from various levels in policy and operational decision-making. The model represents the values of interdependence, collaboration, partnership and accountability as a basis for operational decision-making.

A number of other studies, although limited, explore managing change in culture. Very few have been carried out in the UK and fewer in the NHS. Studies tend to be reflective or descriptive (Carroll, Rudolph and Hatakenaka 2002, Worthington 2004, Smith 2004), versus empirical research, although some studying events such as mergers in healthcare organisations in England discuss the importance of context and the role of organisational culture (Fulop *et al.* 2005). Some start to highlight the importance of leadership and the roles of leaders in achieving change although few (if any) then study or examine this in depth. Jackson (1998, Jackson and Hinchliffe 1999) conducted two studies in the UK, one looking at the role of a leader in cultural change (1998), exploring work in one directorate of one trust, and another (1999) addressing organisational culture through establishing responsive development programmes. Important aspects of behaviour required were identified, behaviour being supportive of organisational goals, decisions being made at the appropriate level by people who had to live with them, co-operation and

teamwork, organisations being supportive of the needs of employees and matrix communication. Brooks (1996) UK study explored the successful role of leaders in initiating and sustaining a major process of change in an ethnographic study via 20 interviews in one trust hospital. Results showed that successful leadership of cultural change requires leaders to think culturally, to be guided by a cognitive model of change and to employ cultural tools of symbolism. A highly receptive context assists by providing a trigger for change. The paper explores the importance of context and, in line with other literature (Alimo-Metcalfe and Alban-Metcalfe 2001), suggests that the softer more symbolic and less tangible aspects of leadership are just as important in securing transformation as more tangible hard structures and system changes. The author suggests that two imperatives in the management of cultural change are the leader's ability to think culturally and to conceptualise the change process via a working model. (Brook 1996, Brook and Bate 1994).

Exploring leadership and culture

Transformational leaders are said to be characterised by their capacity to develop a sense of mission, pride and trust amongst staff, an ability to motivate, to inspire better performance, and through their capacity to challenge staff with new ideas and approaches (Bass 1985). Schein (1985) and Trice and Beyer (1993), suggest that transformational leaders acquire these capacities through a change in the organisational culture. Indeed Trice and Beyer argue that many forms of leadership, transformational and transactional, are really variants of cultural leadership. There is an assumption in some of the literature (Kotter and Heskitt 1992) that leaders can act independently from organisational culture, making the assumption that organisational culture is something that can be viewed as primarily the outcome of senior management strategy in action. Such a view does not acknowledge that culture is the product not simply of what leaders do, but of what others do, or not do (Giddens 1984). Within the literature there is a feeling that cultures are not created by the top of organisations, but co-created by leaders and

their followers (Millward and Bryan 2005, Weick 1995), but little of this has been examined in practice.

Leadership is afforded a central role in many models of cultural change and is a prominent theme in lots of literature (Pettigrew 1979, Schein 1985, Bryman 1996, Smircich 1982). According to Schein (1985) the essential function of leadership is the manipulation of culture, and the essential difference between leadership and management is their orientation towards organisational change, with leaders engaged also in the task of managing the underlying organisational culture. Throughout the change management literature therefore, the importance and central role of leadership is constantly highlighted, particularly that of transformational leadership style (Bodenheimer *et al*. 2004, Manley 2000, 2000a). Walshe (2000) points out that the NHS has largely espoused transactional leadership approaches in practice and argues that the professionally dominated organisational culture of healthcare organisations has not been receptive to a flamboyant transformational style of leadership. However, the agenda of improved quality seems to demand greater attention to the transformational component of leadership especially from NHS Boards. According to Schein (1985), cultural norms define how organisations define leadership, and how leaders create and manage culture, and one of the talents of leaders is their ability to understand and work with the culture. Schein highlights that the functioning of leaders and organisations are not just dependent on the culture of the organisation itself, but on the environment in which it exists. Leaders' roles are often referred to as 'managing the culture' and Anthony (1994) sees this as the management of 'cultural characteristics' versus the management of the structural environment. Leadership is essentially to do with the creation of values which inspire, provide meaning for and instil a sense of purpose in the members of an organisation. The leader is the person who actively moulds the organisation's image, and provides a sense of direction (Bryman 1986:185). Arguably then, leaders have an important influence on culture but little work has been done exploring this. Anthony, Schein, Handy

(1985) all examine strategies of cultural change, leaders roles, types of culture and classifications and how culture and values can be changed, but none examine leaders' roles in and working with the culture.

Within situational approaches to leadership, it is the structure and characteristics that are important. Style and personality are interrelated, but have been looked at separately, and have largely been linked to behaviour and effectiveness, rather than how and why personality and style change with situations and their relationship to culture. Contingency theories in looking at performance explore the context in which leadership occurs and theories such as path goal theory explore relationships between style and characteristics of followers in a work setting. Situational factors are proposed to affect a leader's style, either singly or in various combinations. A related assumption is that compatibility between leaders and cultural preferences is an essential requirement for the former's effectiveness. Situations discussed in the literature which moderate leader effectiveness generally pertain to: the nature of the task; the needs and characteristics of followers and their relationship to the leaders; the organisation's or group's characteristics, such as climate, size of the group, and surrounding culture (Sinha 1995).

Systems approaches see organisations as having 'identity' (Malby 2006). The enduring distinctive character of the organisation (Luhmann 1986) is reflected in values, traditions, symbols, practices and the way the organisation translates or interprets its environment (Gioia and Thomas 1996). Leaders shape identity, how the organisation makes sense of its work and its environment, what relationships matter, what feedback counts, what information is available; and leaders views and behaviours are shaped by the organisations norms and boundaries. Milton and Westphal (2005) report that organisations that manage what they refer to as 'identity confirmation' will be better able to achieve the cooperation they desire. Thus when cooperative effort is aligned with organisational goals, performance will tend to follow. Convergence about collective identity increases organisational

commitment, strengthens organisational culture and mobilises cooperation (Malby 2006). Collective identity is produced through processes (such as language that embodies 'we') (Handy, Lawrence and Grant 2005). These and others (including Malby and Fischer 2006) suggest that organisations that enable collective identity are more likely to be successful, and that identity is produced through collective sense-making, reflection and language. The leadership role therefore is to focus attentions and contribute to the process (Malby 2006). If leaders do shape culture, in relation to how they might do that Schein (1992) identifies these primary mechanisms for embedding culture:

- What leaders pay attention to – measure or control
- Leaders reaction to critical incidents
- Criteria for resource allocation
- Role modelling, teaching and coaching
- Observed way of allocating rewards and status
- Observed criteria for recruitment, selection, promotion and retirement

As highlighted by Malby, if your starting point is organisational culture as the major determinant of organisational effectiveness, then leadership effectiveness will be congruent with the impact leaders have on symbols, language , ideology, beliefs, rituals and myths (Pettigrew 1979).

In using a complex systems view of culture, the approach requires persistent attention to identity, relationships and information (Wheatley and Rogers 1996). They suggest that culture is an emergent property of the interaction between, identity, relationships, information and feedback (Malby 2006). In this model not only do leaders need to give their attention to the structure of identity, but also to the way identity shapes how members make sense of their context, their impact and their work together. The leader's task is to question underlying assumptions

that shape decisions, interpretations and to expand the lens through which the organisation interprets and makes sense of its environment and its own activities.

In some of the work undertaken support from senior managers has been found to be crucial, with a close link being found between the style of top managers and the culture of the organisation (Alveson 1992, Hofstede, Neuijen, Ohayv and Saunders 1990, Alimo-Metcalfe and Alban-Metcalfe 2001, Degeling, Kennedy and Hill 1998). Alimo-Metcalfe and Alban-Metcalfe's study reports that the NHS must encourage and facilitate development of a climate of change and such a climate must be based on overt recognition of principals that include integrity, openness and transparency, valuing others, and delegation that empowers and develops potential (Alban-Metcalfe 2004, Alimo-Metcalfe and Alban-Metcalfe 2006). The study found that a deeper understanding of cultural issues in organisations is necessary to identify what may be the priority issues for leaders and leadership. Kotter (1990, Kotter and Heskett 1992) cites three different importances to culture: it can influence whether or not executives look for and develop people with leadership potential; it can influence whether or not people with leadership ability are encouraged to lead; and the key to leadership development is culture. He highlights that it takes strong leadership to create a useful culture and only with certain kinds of cultures does one find competent leadership emerging throughout an organisation.

Schein (2004) also highlights that culture is shaped by leadership behaviours however examples cited are from the private sector only. Hofstede, Neuijen, Ohayv and Saunders (1990) found that followers and leaders did not appear to influence seven out of nine of the cultural areas studied (three sets of values, four perceived practices) that they examined but had influence on two perceived practices: whether people in their organisation were employee or job orientated and the degree to which the organisational climate was perceived as closed or open. The philosophy and culture clearly reflected the philosophy of top leaders but couldn't rule out that the philosophy of the leader was a reflection of the organisational

culture (Alvesson 1992). All studies look at relationships and styles but the styles and the 'how' differ. In some more emphasis is on changing the situations and in others it is on leadership style.

Within the literature different types of culture have been described as having different types of leadership (Gerowitz 1996). Gerowitz examined the role of top management team culture in 265 hospitals: 45 located in Canada, 100 in the UK and 120 in the US. The study employed used the Competing Values Framework (CVF) to measure strength and content (values) and cultural congruence across six domains, using five measures of performance: employee loyalty, stakeholder satisfaction, consistency, resource acquisition and adaptability. The CVF is a well validated framework (Cameron 1991), based on responses to four questions using a scenario methodology. It has been applied to institutions of higher education, industrial settings and public and service organisations in the US (Gerowitz 1996). The scenarios stimulate individuals to interpret their organisation's culture in relation to four competing types. Within each of the four types, four attributes are embedded. The four attributes are: staff climate, leader style, reward systems and strategic emphasis (the ranking of goals that define organisational success). Each attribute contains four scenarios, one consistent with each cultural type. Ideal cultural types are characterised by a particular style of leadership that reinforces and shares its values, staff climate and reward systems. Cultural type is defined by the dominant quadrant, which is the quadrant with the highest score summed across the attributes of staff character, success goals, and leadership style. The greater the average number of points assigned to a given quadrant, the greater the strength of the culture. Each ideal cultural type is also characterised by a particular style of leadership that reinforces and shapes its values. The four main types of culture are: clan; hierarchy/empirical; open/developmental; and rational, and have since been used and referred to in other studies (Scott, Mannion, Marshall and Davies 2003a).

Findings suggest hospital management teams' culture in the UK were clan and hierarchical in contrast to the other two countries (the US and Canada). The study does provide support that culture is linked to performance, but only in relation to the types of cultures valued by their individual organisations. Questions are also raised in relation to leadership and to the styles of leadership associated with cultural type which is illustrated in Appendix 7. The study was only exploring the role of senior managers and the sample for the study was identified by the chief executive officers (CEOs), which could have introduced some bias. It would have been interesting to have redone this study at differing levels within the organisation, as there is some (limited) evidence to show that employees at different hierarchical levels and in differing work areas systematically differ in perceptions of their organisational culture (Hofstede, Neuijen, Ohayv and Saunders 1990, Helms 2001).

With regard to climate, although leadership and climate are implicitly linked theoretical development and empirical research are limited. Gil, Rico, Alcover and Barrasa (2005) review early theories and research in which leadership is proposed as an organisational factor affecting perceptions of climate. In a study by Lewin, Lippitt and White in 1939 varying leadership styles induced experimentally (authoritarian, democratic and laissez faire) influenced perceptions of climate and behavioural responses. Lewin and Stringer (1968) obtained similar results. Kozlowski and Doherty (1989) found that the interaction between leaders and followers influenced their perceptions of climate. Analysis of both leader's and follower's interactions in primary healthcare teams also confirmed positive relationships between leadership styles and perceptions of climate (Gil, Rico, Alcover and Barrasa 2005).

Studies of the relationship between leadership and climate have been confined to exploring links between dimensions of leadership (focusing on the task and relationship) but do not consider change. No studies seem qualitatively to look at

the relationship between climate and leadership behaviour and certainly none in healthcare. Gil, Rico, Alcover and Barrasa's findings provide empirical support for links between innovative climates and change orientated leadership and outcomes, performance and satisfaction. The study was conducted in 78 healthcare teams with over 300 health professionals in hospitals in Spain. The authors emphasise the consideration that needs to be given to identifying other variables by leaders and organisations. For example, if the influence of leadership on outcomes is explained by climate, it would make sense for leaders to promote change when the climate is considered positive.

The level of empowerment within an organisation varies according to the extent to which the context, culture and structure promote and facilitate empowerment (Honold 1997). According to Kanter (1993) work environments that empower are those in which access to information, support and resources necessary to accomplish work are available as well as those that provide opportunities for growth and development of knowledge and skills. Information about organisational vision is important because it enhances an individual's ability to make and influence decisions that are appropriately aligned with an organisation's goals and mission (Lawler 1992). Spreitzer (1995) found that a participative climate was related to empowerment with employees believing that they were important assets in the organisation and that they could make a difference. In a review of the organisational characteristics that assist in the integration of empowerment programmes, Quinn and Spreitzer (1997) identified four key levers: a clear vision and challenge; openness and teamwork; discipline and control; and support and a sense of direction. They concluded that in order for managers in the NHS to create an empowering environment they needed to show continuous commitment to the management of all these factors.

In the NHS it has been argued that the dominant factor in clinical effectiveness, practice development and successful outcome achievement is that of culture

(McCormack *et al.* 2002:97). Manley (2000, 2000a) argues that it is the culture at individual, team and organisational levels that creates the context for practice. Recent studies have also started to explore the introduction of evidence based practice and what facilitates the introduction of evidence in practice (Kitson *et al.* 1996, 1998, McCormack *et al.* 1999, 2002, Ward and McCormack 2000). Key findings include the need for developmental contexts and cultures and strong leadership. Links with learning organisations were found, where value was given to the contributions of individuals, having open, devolved decision making, shared vision and quality organisational systems which tended to build innovative facilitative cultures (Schein 1985, Senge 1985). The development of a learning culture is now a dominant theme in strategic plans of health organisations and policy papers, via a drive to improve standards, bridge the perceived practice theory gap, and create a means of integrating theory with practice. Initiatives to create such changes have included clinical supervision, reflective practice and professional development.

Key factors in the context of healthcare practice in the United States appear to have had a significant impact on outcomes and performance (Aiken, Sloane and Sochalski 1998). The most recent systematic studies of context and underpinning cultures have been conducted in Magnet Hospitals within the US (McCormack *et al*. 2002, Aiken Sloane and Sochalski 1998). Magnet Hospitals, so called because of their ability to retain staff, have been associated with certain organisational attributes in nursing that have been positively linked with staff outcomes and performance (McCormack *et al*. 2002, Aiken *et al.* 1998). Aiken *et al*. suggest that hospitals that enable professional autonomy and decision making will be ones in which nurses are able to exercise professional judgement with positive results on the quality and outcomes of patient care (McCormack *et al*.2002:94). More recent qualitative studies of Magnet hospitals indicate higher levels of job satisfaction and empowerment among nurses when compared to those in non-magnet hospitals (Upenieks 2003). Key elements accounting for these differences included greater

visibility and autonomy and the existence of appropriate and adequate infrastructures and resources such as staffing. Whilst these studies again allude to the important role of leaders and leadership in describing context, few however go beyond describing its importance and little attention is paid to consideration of other interrelated factors such as hierarchy, differing professional groups and roles.

In terms of nursing in the United Kingdom little work has been undertaken. The emergence of clinical governance (DOH 1998) introduced a means of integrating quality improvement systems, professional development and increasing accountability. However, problems associated with integrating evidence into practice and changing clinical practice have been well documented (Kitson, Harvey and McCormack 1998). Ward and McCormack (2000) present an account of a practice development strategy that aimed to create a learning culture, and describes the context of the development strategy and some tentative outcomes achieved. The paper focuses particularly on nursing and on ways in which nurses in a particular hospital developed when the appropriate conditions for learning were provided. The setting for the study was a 130 bed NHS hospital, where concerns had been already identified in terms of practice, poor leadership and a top down authoritarian culture. It was agreed that improvements were required in three areas: standards of patient care; the development of nurses; and changes to organisational strategy - clearly demonstrating the need to 'change culture' via leadership.

Evaluation focused on two key themes: improvements in patient care, and moves towards creating a learning culture. This is an important study for a number of reasons. From an anecdotal perspective, the study typifies working in the NHS. It is one of few studies that demonstrates the need for cultural change, and ways this can be addressed via transformational leadership rather than transactional management. It is also a rare example of a qualitative study using multiple methods, actively working with practitioners in the system. Having taken into

account other possible variables and explanations for improvement, links were established between increased leadership, learning, and a change in styles of leaders, changes in clinical practice and improved patient care. A number of examples are given, including increased motivation, increased accountability and responsibility of staff and leaders.

A number of studies, largely descriptive reviews rather than empirical studies or in-depth evaluations, and primarily discussing change management in healthcare, focus on the importance of leadership in cultural change (Jackson and Hinchliffe 1999, Narine 2003, Brooks 1996). Jackson and Hinchliffe's study focused on changing the culture in nursing within a large District General Hospital in the early 1990s. The study uses Gorden's (1987) five key guidelines to cultural change, the first three of which relate to the importance of leadership, and the study discusses important links between leadership at the top and changing practice and culture in nursing. Brook's ethnographic study explored the role of leadership in initiating a significant change programme over five years in a large general hospital and leadership at the top of the organisation. The study reported that leadership changed the context and culture via leadership behaviours, described at the end of the study to be more dynamic and risk taking. No real details were given on methods, samples, actual data or leadership behaviours. What were discussed are behaviours in relation to change management, where parallels and links can be drawn with organisational culture. Narine's study also discussed similar factors and aimed to provide insights into practices that could be utilised to improve the chances of successful change management. The study listed a number of factors felt to be crucial to successful change including gaining commitment, clear vision, participative approaches and managing the change. Leadership is also flagged up as important by other general change management literatures and despite (in most cases) a lack of direct empirical evidence, a link can be made with all these factors and leadership, where there is a direct correlation in terms of factors needed to effect successful change, and transformational leadership.

The literature on change management suggests that concentration should be on leadership and leadership behaviours that will achieve change and a change in culture. For this reason the change management literature, although not directly relevant is very important. Firstly, because a lot of the associated factors correlate with leadership qualities, and secondly because they concentrate on strategies which focus at system rather than individual level and aim to change group or team behaviours and practices - a key aim of leadership.

According to Kerfoot (2004) leaders who grow up in a negative culture learn and lead by faultfinding. Kerfoot states that leaders can instil confidence or fear and many other reactions in the environment, but that there is no evidence to support the effectiveness of a culture of fear and intimidation and extensive evidence to support the positive outcomes of a culture of confidence. Rosabeth Moss Kanter (2004) writes that *"leadership is not about the leader it is about how he or she builds the confidence of everyone else"* (2004: 325). When examining successful wards in the US Kanter articulates that the confidence of staff remains one of the most important differentiating factors, feeling that confidence in other people is the most essential ingredient in leadership. In her analysis of leadership she writes that leaders who build confident organisations firstly communicate a belief to all that it is possible to meet high standards, and secondly create a sense that there is a purpose worth achieving. Within nursing she views three factors as being important in creating a conducive culture, climate and atmosphere. These are: creating a culture of confidence with positive confident interactions among each other; building an infrastructure that creates confidence; and focusing on activities that will inspire and motivate. The rules of culture determine behaviour and the role of the leader is felt by Kerfoot to be critical here. She feels that bad or inappropriate leadership behaviours endure because there is not a strong message from the leader that these behaviours do not fit in with the value system. However these are her views and whilst they seem to make sense few if any empirical studies have examined these factors and or relationships. By contrast, the leader

can create cultures of confidence when the norm is to be positive and enthusiastic. Kerfoot articulates therefore that leaders have a clear choice to create either a culture that is thriving and positive or one that is disengaged and negative.

Brazier (2004) reports on a review of the literature and draws on evidence to extend understanding of the influence of contextual factors on power and influence, creativity and innovation and on leadership behaviour. A review was done of key databases from 1999-2004, however no in depth description of the associated studies are given. The study reviewed a number of key themes: power and influence, creativity and innovation, and leadership behaviour. The effects of relationships between leaders and followers were considered and, indirectly, links with the culture and structure of organisations. In relation to leadership, the study considers specific leadership models rather than exploring the general theme of leadership and does not discuss effects on leaders but influences on staff, and links indirectly to performance and job satisfaction. That said a number of interesting points are made:

- Certain types of power and position are particularly important, and the ways these are enacted affect staff, e.g. by making people feel valued and important and by the sharing of technical expertise, experience and knowledge with followers.
- Empowerment and trust, participative work environments, with access to support and resources provide opportunity for growth and development.
- Positive creativity is encouraged in flexible organisations which seem to have flatter more devolved structures.
- Bureaucratic organisations can inhibit an empowering environment as can those that are poor at disseminating information or communicating a vision.
- In hierarchical structures, high staff turnover and a lack of resources are likely to stifle creativity and innovation.

- Organic structures tend to facilitate a more transformational leadership style, whereas bureaucratic structures encourage a more transactional style.

In conclusion, Brazier highlights the lack of work done in this area, but makes a number of observations. Firstly, if organisations wish to nurture and develop leadership they need to be mindful of the environmental context within which this takes place. Secondly, the level of empowerment within an organisation varies according to the extent to which the culture and structure promotes and facilitates empowerment all of which present particular challenges for the NHS. The final section of this chapter attempts to summarise the key points of this review and sets out aims of this research study.

Part Three

Research aims

Both the leadership and culture literature are diverse and contested, with lots of different models, and relatively few dominating the literature. However some common themes emerge. In broad terms the criticisms made are that the literature has little to say about informal leadership processes and has ignored contextual and cultural issues and constraints in organisations (Mannion 2005a). Having conducted an extensive review of the literature a number of issues can be crystallised into four areas:

- Leadership has been studied in a variety of ways depending on the researcher's methodological preferences and definitions.
- A number of studies still fail to make a distinction between leadership and management and continue to use terms interchangeably.
- Most studies have been quantitative, have emerged from the US and have studied senior leadership. Little research has been done within the health service to explore current roles, issues and practices.
- Understanding the culture of healthcare and its relationship to leadership appears fundamental to accomplishing any effective sustainable change and improved outcomes.

It can perhaps be taken as a starting point that there is a relationship between leadership and culture but the exact nature of this needs exploration. There appears to be a common hypothesis that if an organisation has 'strong leadership' or a 'strong culture' by exhibiting a well integrated and effective set of specific values beliefs and behaviour patterns then it will perform at a higher level (Dennison 1984). This view however has been criticised (Scott, Mannion, Marshall and Davies 2003) and researchers have not identified the variables in culture that

affect leadership or performance or leaders relationship with organisational culture. Earlier leadership theories have argued implicitly or explicitly that situational settings and organisational climate are crucial determinants of actual leadership behaviour (Yukl 1989, Brazier 2004). One of the most recent theories of leadership explores the transformational versus transactional approaches. Effective leaders are felt in practice to use a combination of the two (Bass 1985, Kotter 1990). However, recent debates have tended to treat transformational elements of leadership either too simplistically or too universally. For example in the NHS the leadership of a frontline manager, CEO and a staff nurse are likely to be remarkably different. This is alluded to within much of the literature reviewed, but within the NHS this is not an area that has been explored and until very recently there have been few empirical studies. Policy interest appears to be around the fact that 'better leadership equals better care', which appears to be based on two main assumptions. The first is that in the absence of strong and effective leadership others will not act and change will not happen. Leaders are necessary to generate ideas and provide direction which inspires and motivates followers. The second is that leaders are rare and gifted individuals and initiatives such as the leadership centre are often designed to identify and nurture those capabilities where possible. Recent commentary and studies have challenged these assumptions.

In relation to the study of organisations particularly within the public sector and the NHS, literature suggests the existence of two related but differing concepts of leadership. Firstly, that which could be termed strategic leadership or 'leadership of organisations' and secondly supervisory leadership or leadership which takes place 'in organisations'. Strategic leadership therefore could encompass more senior roles within organisations and those referred to by Alimo-Metcalfe and Alban-Metcalfe (2001) as 'distant leaders'. This style of leadership is concerned with the creation of meaning and with the evolution of leadership of organisations as a whole, including clarifying aims and responsibilities. As such, it focuses on people who have overall responsibility for the organisation. Supervisory leadership in

contrast focuses on the task and person centred orientated behaviours of leaders as they attempt to provide guidance, support and feedback to followers. This type of leadership is perhaps more equated with leaders who lead in middle or first line management or leadership roles – highlighted in recent studies as 'near leaders' (Alimo-Metcalfe and Alban-Metcalfe 2001).

When considering leadership roles in nursing and these two concepts of leadership a number of roles relate to both models, in that roles such as nurse consultant or lead nurse encompass both strategic and supervisory styles of leadership. Having reflected on the literature an initial conceptual framework illustrating these concepts was developed, as illustrated in Figure 2.1 on page 106. The framework attempts to demonstrate the interplay between these two models and the linkage and involvement of other factors influencing leadership in practice within the NHS. One of the important elements of the framework is the position of nursing leadership within the two concepts of leadership and its relationship to them. Antrobus (1999) illustrates this very well and the complex nature of nursing leadership, referring to it as the bi-cultural nature or role of nursing, in that its expanse is often expected to encompass many domains namely, political, clinical, academic and executive roles and leadership. These four domains are illustrated in Figure 2.2 on page 107-.

New paradigm models and studies are American and focus on distant leaders and, as highlighted by Alimo-Metcalfe and Alban-Metcalfe (2001), why should we assume they are relevant to UK and public sector organisations such as the NHS? There are characteristics of the healthcare industry that distinguish it from other industries and although some managerial processes may be similar, culture, practices and regulatory frameworks differ and can promote or hinder efforts to

Figure 2.1 Conceptual framework

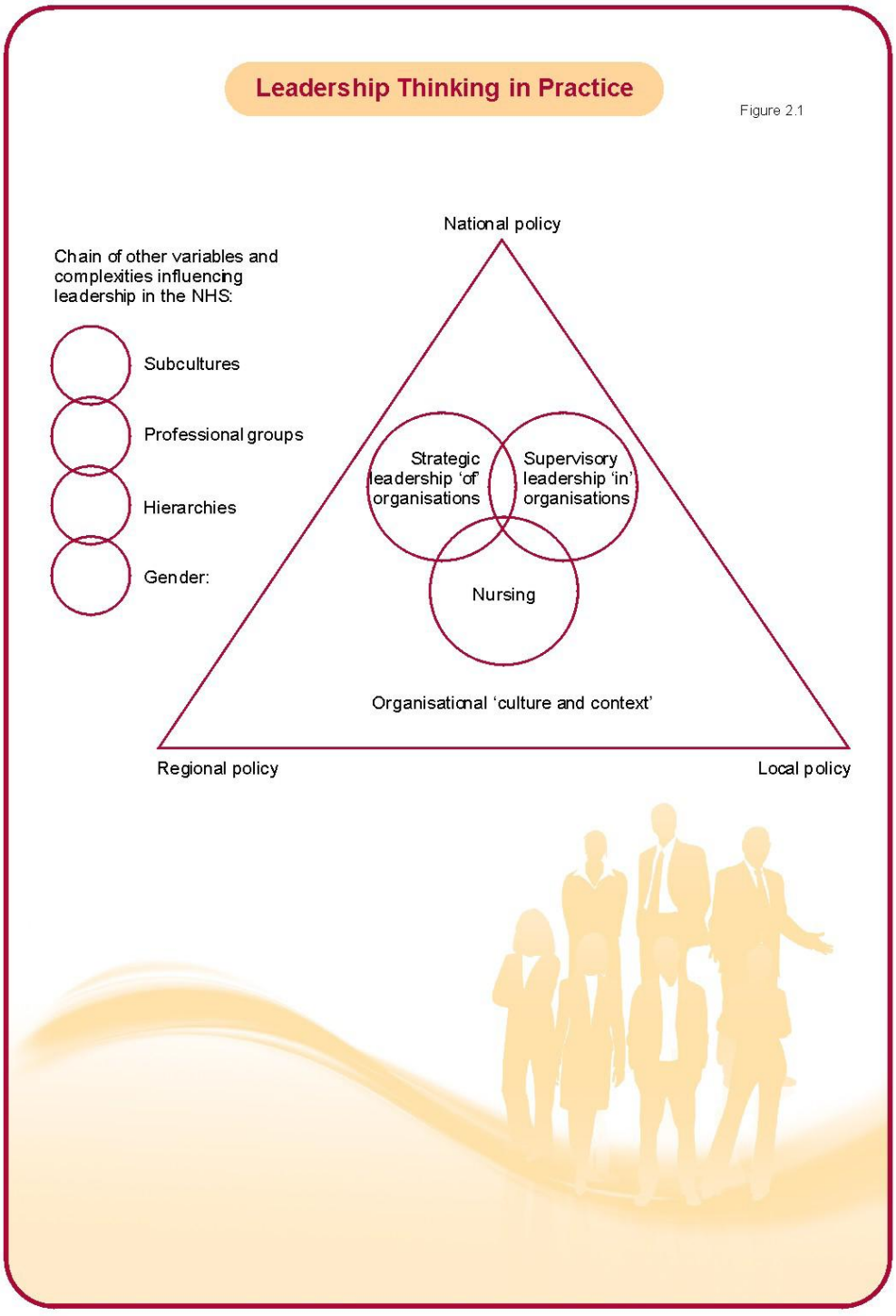
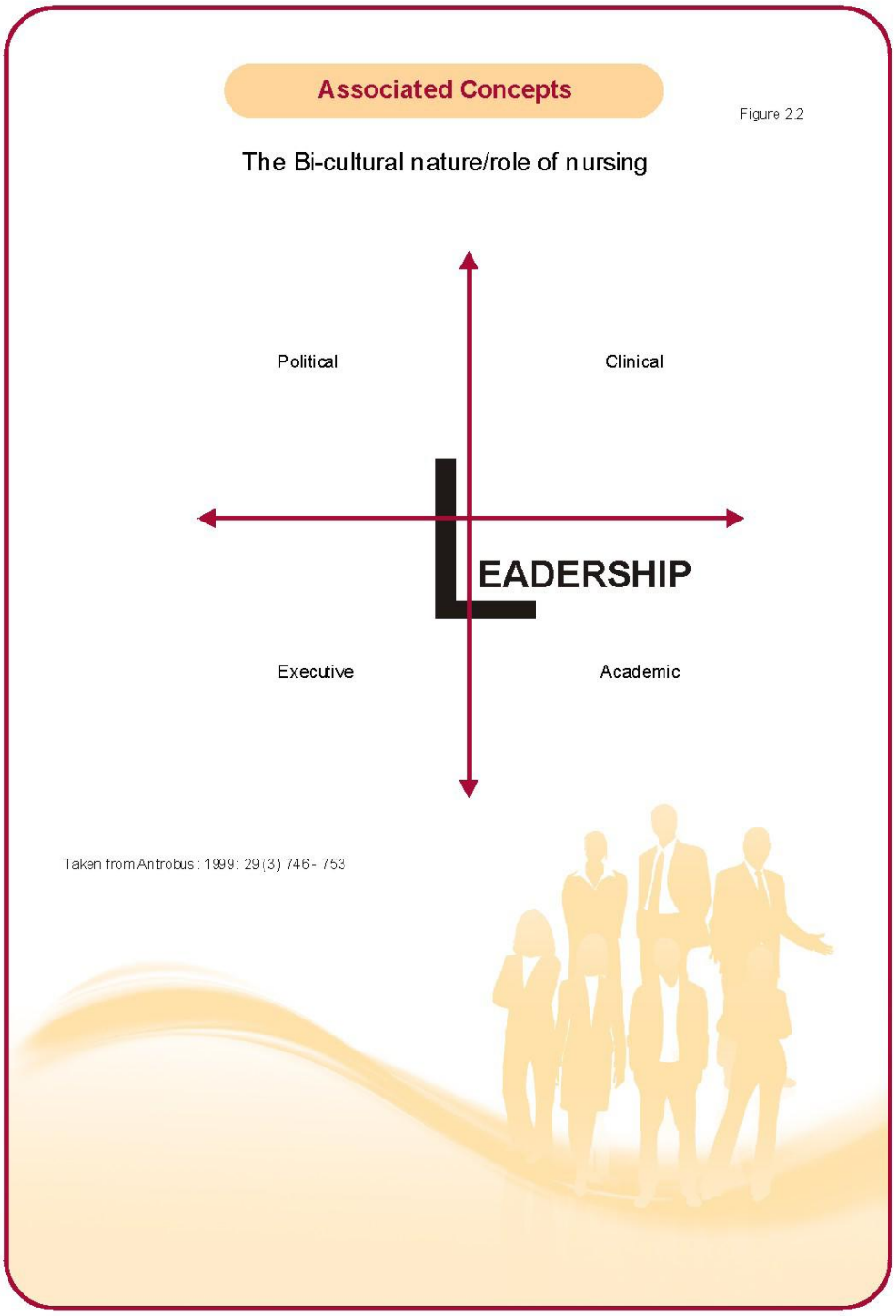


Figure 2.2 Associated concepts



improve performance. These characteristics influence the extent to which other models and practices are relevant and transferable to the healthcare sector. Links have been established in the literature between the culture of organisations and leadership skills, roles and behaviours (Alimo-Metcalfe and Alban-Metcalfe 2002, 2003, Storey 2004, Schein 1985, Mannion, Davies and Marshall 2005). However, despite all the increasing emphasis on the importance of leadership roles and behaviours in establishing change in the NHS, and the key leadership roles and expectations developed and placed on nursing over the last decade, very little (if any) research on the nature of these behaviours and links, or on their relationship in practice has taken place. This thesis therefore proposes to develop an understanding of leadership characteristics, styles and behaviours within nursing. Specifically this research aims to:

- Explore how leadership and leadership behaviours within the NHS and particularly nursing, function in practice.
- Explore what part the environment, context, organisational culture and the dynamics of NHS organisations play in how these leadership behaviours and roles develop and function.
- Explore how these might help us understand the issues facing nurses, nurse managers and health boards in modernising and implementing new leadership roles.

The following chapter discusses the rationale in relation to the methodology and methods employed for the research, describing the study design and implementation.

Chapter Three

Methodology and methods

Introduction

The previous chapter reviewed the literature in relation to leadership and organisational culture and concluded with the research aims to be addressed in this study. The research aims and review of the literature led to the choice of a qualitative case study approach. This chapter considers the rationale for this choice and goes on to describe in detail how the study was carried out.

In exploring choices of methodology and methods in relation to leadership and culture, methodology and methods employed need to be dependent on how these phenomena are conceptualised, the purpose of the investigation and intended use of the results. Having reviewed the literature, based on evidence available and anecdotal experience, leadership and leadership roles should be studied in relation to the context in which they occur, and due to the complexities of the NHS any in-depth exploration is more suited to qualitative methods of enquiry. The functioning of leadership roles are often highlighted as being dependent on various variables, particularly those of context and culture and relations to structure, hierarchy and power. This highlights the difficulty of considering leadership alone as an object of study aside from all other organisational factors in play. Gaining an understanding of the overall context is crucial and raises the question not of whether leaders make a difference but, more importantly, under what conditions they can make a difference. Leadership can only be understood in relation to the context in which it occurs (Goodwin 2006, Fielder 1967).

Methodology

Research approach

Reflecting the research questions, this research took a qualitative, naturalistic and constructivist approach to inquiry, employing qualitative methods of data collection. Qualitative research establishes an empathetic understanding through 'thick description' (Geertz 1973). This looks to explain reasons for actions and behaviours but also their context as well, in ways that behaviours become meaningful to outsiders. It is based on the particular perceptions of participants, seeking to provide a holistic view of situations or organisations that the researcher is trying to understand (Patton 1990). Most contemporary qualitative researchers believe that knowledge is constructed rather than discovered (Lincoln and Guba 2000). People construct and develop understandings from experience and being told about what the world is like. The world is viewed as having multiple perspectives and therefore there is no way to establish the 'best view' or a consensus view. The process of inquiry develops and verifies shared constructions that enable the meaningful expression of knowledge. Lincoln and Guba (1985), strong advocates of the naturalistic approach, consider realities as multiple, constructed and holistic. The knower and known are seen as interactive and inseparable. The aims of researchers are to produce working hypotheses and case based knowledge. The emphasis in naturalistic inquiry is on: natural world and context; starts from the stance that the phenomena should be studied in their natural setting; and is committed to detailed descriptions and to 'tell it like it is' (Lincoln and Guba 1985, Erlandson 1993).

Emphasis is on the 'real world', exploring the how and why, and is context dependent. This stems from the fundamental assumption that all the subjects of inquiry/research are bound together by a complex web of unique inter-relationships that result in mutual simultaneous shaping (Lincoln and Guba 1985). Adapting a contextual perspective recognises the influence that context and situations have on

behaviours and behaviours have on situations. In organisational research particularly, considerations of context are paramount, and the field itself is defined by the context of organisational life (Cassell 1999). There is a belief that human action can be investigated only by gaining access to the meanings which guide it. This involves learning the culture or sub-culture of the people under study and means that the social world cannot be investigated under artificial conditions, but only in naturally occurring situations. In line with this approach this study sought to describe what happens in social settings, how people involved see their own actions, and the context in which that action takes place.

The deeper understanding the researcher gains of the setting and the persons in it, the more his/her own constructions will be affected. Realising this, in this study the researcher did not attempt to isolate themselves from the setting but sought to establish relationships through which the natural shaping of constructions is a collaborative exercise in which researcher and respondents voluntarily participate (Erlandson 1993). The importance of contextual sensitivity is referred to by Silverman (2002), noting that roles and identities take on a variety of meanings and are negotiated in different contexts and settings. Far from being fixed essences, he argues that these are in fact quite changeable, depending on the social context in which they are evolved. Thus they can be understood as social constructions. The primary purpose of gathering data therefore, in naturalistic inquiry, is to gain the ability to construct reality in ways that are consistent and compatible with the constructions of a setting's inhabitants. This requires the researcher to be able to experience what people experience and to see that experience in the way that they see it.

Study design

One of the most effective means of adding to understanding therefore is by illustrating through the research the natural experiences acquired in ordinary personal involvement, and gaining perceptions and understandings that come from

immersion in and holistic regard for the phenomena (Stake 1994, 1995). This highlights the need for the use of design and methods to elicit and share human constructions of reality in social contexts which aim to develop and allow flexible thinking. Views and thoughts are validated by their contributions to understanding the context in which the observed events can and do take place. To isolate any one aspect from its context destroys much of its meaning. Qualitative methods allow the detailed analysis of change and in organisational research, organisational dynamics and change are major areas of interest (Denzin and Lincoln 2000). The flexibility of approaches allows the researcher to follow leads that emerge. Within qualitative research case study design is a flexible and adaptable method which centres around the importance of context and the need to thoroughly understand the case (Gomm 2000).

Case studies can be undertaken in different ways but have a number of common features. Many start by asking broad questions such as what are the intended effects, and what are the important features and relationships that will affect the outcome of an initiative. Asking participants about their experiences and observing them in meetings and other work settings can provide rich data for descriptive and explanatory accounts of the ways in which policies and more specific interventions work and their subsequent impact. They are often considered most valuable where a planned change is occurring in a messy and real world setting and when it is important to understand why such interventions succeed or fail. Many interventions will typically depend for their success on the involvement of several different interested parties, so it is necessary to be sensitive to issues of collaboration and conflict, which traditional health service research approaches are not designed to address. A range of methods may be used including interviews, analysis of documents and non-participant observation of meetings or quantitative and qualitative methods may be combined. This study initially comprised of two exploratory case studies with comparative elements. However for reasons that will be explained later, case boundaries ultimately became insignificant and the

research became a qualitative study on what could be described as one case, that of leadership in the NHS in two health boards in Scotland.

Case study approaches and designs

Considerable literature exists discussing case study approaches and designs, all adopting and advocating slightly different approaches, although with some similar core themes (Yin 1994, Stake 1995, Gomm 2000, 2000a, 2000b). Generally a case study can be said to be an empirical inquiry and research strategy that investigates a contemporary phenomenon within its real life context; and is a design especially suited if the boundaries between phenomenon and context are blurred (Yin 2004). Emphasis is on the importance of context and studying and observing the phenomenon or case in its ordinary setting or place. Interest is on uniqueness of cases, commonality, differences and interests in how they feel and function. Generally, case studies fit with more qualitative approaches to data collection which seek a greater in-depth understanding in a particular complex phenomena or case. The difference from other research designs is that the case is the focus of interest in its own right. What distinguishes a case study from other types of study is that the researcher is usually concerned to elucidate the unique features of the case. The aim is to generate an intensive examination of a single case which is then subjected to theoretical analysis (Yin 1994, Stake 1995). Concern, therefore, is generation of theory and conceptions out of the data and understanding versus explanation (Bryman 2001, Stake 1995). Case studies are often constructed to allow comparisons to be drawn (Yin 2002). Comparisons may be between different approaches to implementation of the same policy or between sites where an innovation is taking place and one where normal practice prevails. This design entails the study using more or less identical methods with two contrasting cases. It embodies the logic of comparison in that it implies we can understand social phenomena better when they are compared in relation to two or more meaningfully contrasting cases or situations. The aim is to seek understanding for similarities

and differences or to gain a greater awareness and a deeper understanding of social reality in different contexts (Gomm 2000b, Stark 2005, Somekh 2005).

Defining the case

Definitions and descriptions of what might or might not be defined as a case are heavily debated in the literature, with different terminology and descriptions being given by different authors (Stake 1995, Yin 2003, 2004, Gomm 2000, 2000a, Bryman 2001). Cases can be considered to be the phenomenon itself or understanding a setting, group or organisation. Within differing literatures, the importance of setting and being clear about boundaries (what is and what is not included in the case) is highlighted, as is the importance of considering context and the need to consider what can be referred to as external and internal contexts. Stake (1995) refers to the case being a 'bounded system'; Yin is less explicit highlighting that boundaries of what is considered a case are not always clear.

Sampling frame

Rationale

Site selection is important in case studies and two principal approaches are utilised: purposive sampling in which sites are selected on the basis that they are typical of the phenomenon being investigated, and theoretical sampling designed specifically to confirm or refute a hypotheses derived either from previous research or data collected earlier in the same study. The key rationale in sampling in case study research is what will help us understand and study the case or phenomena in the best way.

The current study related to the need to explore how leadership behaviours play out in practice, what parts the environment, context and dynamics of the organisation play in how leadership roles take shape and function, and how might these help us to understand the issues facing nurses, nurse managers and Health

Boards in modernising and implementing new leadership roles and behaviours advocated by Government policy? Some thoughts behind the choice of sample also involved some of those offered by Patton (1990) such as the possibility of sampling extreme or deviant cases, the use of intensity sampling (studying which cases will manifest the phenomena intensely), opportunistic sampling, allowing for the follow up of new leads during field work and sampling politically important cases.

Considering approaches to data generation and analysis

A distinctive feature of case study research is often the use of multiple methods and sources of evidence with the aim of ensuring the comprehensiveness of findings as well as potentially strengthening their validity (Yin 2002). The key aim should really be to allow exploration of the phenomena from a number of different angles, and different sources of data will tend to provide different insights rather than contribute to a single accumulating picture. The purpose of steps followed in designing and building the case study is to maximise confidence in the findings, but interpretation inevitably involves some value judgements and the risk of bias. The extent to which research findings can be assembled into a single coherent account of events varies; individual cases may exhibit common characteristics or function very differently. The case study approach enables the researcher to gauge confidence in both the internal and external validity of the findings and make comments with appropriate assurance or with reservation. Method and analysis occur simultaneously in case study research in an iterative process and the researcher moves between literature, analysis and the field. This can be a strength as it allows for theory development which is grounded in empirical evidence (Hartley 1994). Journals and logs are kept during any observational parts of the study and field notes during data collection. Analysing each case descriptively, on its own, or across cases may depend on if cases were similar or totally different.

Overall approaches to analysis should be influenced by theoretical and methodological perspectives and should relate to the aims of the research.

Different styles of research may require different depths of analysis. The analysis may seek simply to describe people's views or behaviours or move beyond this to provide explanations that can take the form of classifications, typologies, patterns, models and theories. Pope and Mays (2006) liken the analytical structure that underpins this process to scaffolding and suggests that analysis moves iteratively through stages of data management, description and explanation via a series of platforms from which the researcher can reflect on what they have done and move forward. The process is fluid, and crucially, non-linear with the researcher developing analysis by moving backwards and forwards between the original data and emerging interpretations. Qualitative research seeks to develop analytic categories to describe and explain social phenomena. These categories may be derived inductively, obtained gradually from the data or used deductively, either at the beginning or part way through the analysis as a way of approaching the data.

There appear to be three broad approaches for taking analysis forward, thematic analysis, grounded theory and the framework approach (Pope and Mays 2006). In line with the qualitative methods to be employed a number of approaches to data collection and analysis were considered and rejected, including use of the repertory grid, discourse and thematic analysis. In line with case study research, within this study the main method of data collection centred on interviewing, contextualised by the inclusion of some reviews of documentation and some non-participant observation. The key issues for consideration in both the final choice of methods and analysis included enabling a flexible yet structured approach to data collection, which allowed a phased yet data driven approach, and a structured approach to analysis given the number of interviews proposed in two large case study areas.

Having considered broad methods and phased approaches to interviews and a combination of purposeful and theoretical sampling, the researcher decided to employ constructivist grounded theory, (Charmaz 2004, 2006, Allan 2003), supported by the use of thematic network analysis (Attride-Stirling 2001). This

allowed in depth study and analysis, sampling driven by analysis, a flexible but structured approach to data generation and analysis, a diagrammatic presentation of linkages and networks between data, and the continual exploration of highlighted key issues.

Grounded theory

Glaser and Strauss (1967) coined the term grounded theory to describe the inductive process of coding incidents in the data and identifying analytical categories as they emerge from the data, developing hypotheses from the ground or research field upwards rather than defining them in advance. Over the years a number of researchers have developed and taken grounded theory in differing directions, developing, refining and emphasising different aspects, but mainly moving grounded theory away from the more positivist elements (Strauss and Corbin, 1990, Charmaz 2000, 2006, Clarke 2003, Seale 1999, Bryant 2002). Currently grounded theory guidelines describe steps of the research process, suggesting and providing a path through it, with researchers then able to adopt and adapt them as appropriate (Charmaz 2004). As highlighted by Charmaz, how researchers then use these guidelines is not neutral, nor are the assumptions they bring to the research and enact during the process.

Constructivist grounded theory

Charmaz (2006) views grounded theory as a set of principles and practices, not as prescriptions or packages, emphasises flexible guidelines and the possible use of grounded theory as complementary to other approaches to qualitative data analysis, rather than standing in opposition to them. Charmaz (2006) builds on earlier work and discussions and on a symbolic interactionism perspective, viewing grounded theory as a way to learn about the worlds we study and a method for developing theories to understand them. Unlike Glaser and Strauss, Charmaz (2006) assumes that neither data nor theories are discovered, but rather that the researcher is part of the world they study and the data they collect. We therefore

construct our theories through our past and present involvements and interactions with people, perspectives and research practices. Charmaz's approach assumes therefore that any theory developed offers an interpretive portrayal of the studied world not an exact picture of it. We interact with data and create theories about it, but we do not exist in a social vacuum. Constructivist grounded theory is therefore part of the interpretive tradition and places priority on the phenomena of study, seeing both data and analysis as created from shared experiences and relationships with participants and other sources of data. It also:

- Studies how and why participants construct meanings and actions in specific situations.
- Means more than looking at how individuals view their situations. It not only theorizes the interpretive work that research participants do, but also acknowledges that the resulting theory is an interpretation (Bryant 2002, Charmaz 2000, 2002). The theory depends on the researcher's view and it cannot stand outside it.
- May borrow insight from Silverman's (2004) observation of conversational analysis. He contends that only after establishing how people construct meanings and actions can the researcher pursue why they act as they do.
- Looks at how, when, and to what extent the studied experience is embedded in larger and often hidden positions, networks, situations and relationships. Subsequently, differences and distinctions between people become visible as well as the hierarchies of power, communication and opportunity that perpetuate such differences and distinctions.
- Is alert to conditions under which such differences and distinctions arise and are maintained.
- Takes a reflexive stance towards the research process and products and considers how their theories evolve and assume that both data and analysis are social constructions that reflect what their production entailed.

- Considers any analysis is contextually situated in time, place, culture and situation, and sees facts and values as linked and acknowledges what they see and don't see rests on values.

Utilising and applying debates in grounded theory

Traditional research designs usually rely on a literature review leading to the generation of specific areas of interest which are then explored in the 'real world'. In earlier grounded theory work such as Glaser and Strauss (1967) however, authors appear to advocate investigation in the real world and analysis of the data with no preconceived questions, theoretical or conceptual framework. This approach posed challenges for the current study due to the busy schedules of interviewees, who required meetings to have an agenda and research projects to be scoped out. Also in practical terms, time and resource constraints prohibit unfocused investigation. Allen, in an exploratory paper on grounded theory (2003), says however that this view is a misconception of the original premise put forward by Glaser and Strauss (1967:169), and is not what Glaser and Strauss meant. They encouraged researchers to "use any material bearing in the area" and this is taken to include the writing of authors. Allan considers that instead they were referring to preconceived bias and mental baggage, which may be taken to mean preconceived ideas about working practices embedded in the researchers mind (Glaser 2002). Strauss and Corbin (1998) saw the use of literature as a basis of professional knowledge referring to it as literature sensitivity and Dey as 'accumulated knowledge' (1993:66).

The role of prior conceptual frameworks

Definitions and the use of both theoretical and conceptual frameworks and models are the subject of much debate within the literature, particularly in relation to grounded theory and case study design, although they are acknowledged to help shape perception, reality and enquiry (Parahoo 2006). Parahoo (2006) provides a useful explanation discussing the relationship between concepts, propositions and

the development of theory; and articulates that the use of a theoretical framework at the beginning of research is perhaps more appropriate for research underpinned by one identified theory. In contrast the use of conceptual frameworks is explained as drawing on concepts from various theories and research findings to guide the study. By way of illustrating these concepts conceptual models may also be constructed which can diagrammatically represent concepts or theories. Parahoo discusses the use of conceptual frameworks within qualitative research as having a different function from those in quantitative research, where researchers aim to develop their own concepts and theories from the data (Parahoo 2006).

Concerns expressed in the literature state that this could provide a framework that may be inappropriate or incomplete and can be a source of bias (Benton 1996). Morse (1994) echoes these sentiments feeling that knowledge is a possible contaminant, a possible source of bias and a threat to validity. However Strauss and Corbin (1990) describe this as *theoretical sensitivity*, which they define as a personal quality of the researcher and as indicating an awareness of the subtleties of the meaning of data. They point out that this can come from a variety of sources, mainly literature, professional experience and personal experience. They also point out that it can be a stimulus for the research question as it points to relatively unexplored areas, suggests the need for further development or highlights contradictions or ambiguities and the need to look at confirming the approaches to be taken.

This approach was well suited to this study, particularly in relation to theoretical sensitivity. Grounded theory is an approach which does not necessarily have a pre-conceived framework developed from an extensive sourcing of the literature. In under-researched areas there may simply not be many published works available to review. Nevertheless literature is used in a grounded theory study to help clarify initial ideas and a research problem. However, as it progresses it pursues other areas of interest that respondents may define as crucial and evaluates the fit

between their initial research interests and their emerging data and follows leads that the researcher defines in the data.

Yin (1994:13) also suggests that the case study benefits from the development of theoretical propositions to guide data collection and analysis. Case studies are advocated for exploring and illuminating new processes or behaviours or ones which are little understood (Hartley 1994); and in this sense case studies have an important function in generally hypothesising and building theory. In order to do so some tentative conceptual theory or framework needs to be developed with the recognition that the issues and theory will shift as the framework and concepts are repeatedly examined against systematically collected data. Some focus is needed to structure the study to avoid being overwhelmed by the data and being drawn into narrative rather than theory building. Theory building is key to case study and grounded theory analysis but to do this there has to be a theory to examine, contest, and/or find supporting or collective evidence for (Hartley 1994, Glaser and Strauss 1967, Charmaz 2004).

Within this research study the areas of leadership, leadership behaviours, organisational change, culture and context have been written about in some detail, with the application of many models and the subsequent development of many theories. Having extensively reviewed the literature it was felt that no one theory was applicable, but that various concepts shaped debate and facilitated the research proposed and therefore the generation of possible further concepts and related issues for exploration. A tentative framework was therefore developed which set out key areas of debate diagrammatically and was then used to facilitate areas for further discussion and exploration.

Handling data

Data collection in grounded theory usually centres on interviews. However, as with case studies, a range of methods may be utilised, which when combined enhance

and seek to provide a deeper understanding of the phenomena and the setting. Analysis of interview data in qualitative research tends to result in descriptions of an interpretive view of the events and grounded theory data analysis involves searching out the concepts behind the actualities by looking for codes, then concepts and finally categories. Issues of concern have been highlighted around this and the lack of clearly defined coding processes or mechanisms (Allan 2003). Glaser and Strauss (1967) and later Glaser (1978, 1992) do not instruct the reader in a prescribed mechanism for performing the coding and describe the conceptualisation of coding. This could leave the researcher unclear as to precisely what to look for, which is important to avoid the introduction of bias. Glaser (1992) highlights concerns in utilising 'micro-analysis' i.e. line by line as producing 'over-conceptualisation' and advocates identifying key points rather than individual words and allowing concepts to emerge. Allan (2003) in his article describes useful methods to overcome this, utilised in this study, by identifying key points in the interview data and concentrating the analysis on these, although he then highlights other difficulties around knowing when coding should end and when analysis should be complete.

Throughout her work Charmaz argues that the strength of grounded theory methods lies in their flexibility. She argues that researchers should draw on the flexibility of grounded theory without transforming it into rigid prescriptions concerning data collection, analysis, theoretical leanings and epistemological positions and that we can utilise the tools of grounded theory methods without subscribing to a prescribed theory of knowledge or view of reality. It is her view that we are not compelled to view grounded theory as discovering categories that exist in data in an external world. Nor do we need to see grounded theory as an application of procedures, but we can view it as a product of emergent processes that occur through interaction. Researchers therefore construct their respective products from the fabric of the interactions.

A real advantage of grounded theory is that analysis starts as soon as data collection begins in the first interview. Glaser (2002) holds that analysis can start during the first interview if the researcher identifies concepts that are striking at that time. However it is not sufficient simply to inspect data and label interesting points, the data are analysed in a systematic and rigorous manner to discover concepts leading to categories. It is felt that engaging in these practices can help researchers to control their research process and to increase the analytical power of their work (Glaser 1992, Charmaz 1983). Morse (1994) adds that the methodology is process orientated and therefore not just a description of values and beliefs; it allows for changes over time and identifies stages and phases that individuals undergo; and it is useful for eliciting and describing the psychological and social processes that have been developed by people to make sense of their world. The particular goal therefore is to explore the social processes that occur in human interaction and to discover theoretically complete explanations about particular phenomena. Chenitz and Swanson (1986) feel that grounded theory is particularly useful for describing behaviour in complex situations.

Grounded theory is typified by the concurrent activities of data collection, organisation and analysis; the activities being distinct yet connected. The process of analysis and interpretation continues until a theory or theories are developed of sufficient level of abstraction to explain variations of the data observed (Cormack 1996). This approach is described as the constant comparative method. In terms of providing an explanation for data, grounded theory is a version of standard inductive argument. However its strength lies in the potential to articulate a unique context and logic of discovery (Miller and Fredrick 1999).

Thematic network analysis

Attride-Striling in her article (2001) details a technique for conducting thematic analysis of qualitative material, proposing that thematic analyses can be usefully aided by and presented as thematic networks. These networks are described as

web-like illustrations that summarise the main themes constituting a piece of text. As an analytical tool thematic networks draw on core features that are common to many approaches in qualitative analysis, including grounded theory and the core structure has significant parallels with the three basic elements of grounded theory: concepts, categories and propositions. The technique was developed based on some of the principals of argumentation theory (Toulmin 1958) which aims to provide a structured method for analysing negotiation processes. It defines and elaborates the typical, formal elements of arguments as a means of exploring the connections between the explicit statements and the implicit meanings in peoples discourse. Thematic analyses seek to unearth the themes salient in a text at different levels and thematic networks aim to explore the understanding of an issue or the significance of an idea and to facilitate the structuring and depiction of these ideas and themes. These are then represented as web-like maps depicting the salient themes at a number of levels, illustrating the relationships between them. A thematic network is developed starting from the basic themes and working inwards towards a global theme. The networks are presented graphically as web-like nets to remove any notion of hierarchy, giving fluidity to the themes and emphasising the interconnectivity throughout the network. Within this study the use of web-like networks as a means of illustrating the procedures employed in moving from text to interpretation was considered a structured way to build on the memo component of grounded theory, allowing a more detailed way of presenting key linkages and arguments within the data. Therefore combining the two techniques of grounded theory and thematic network analysis in the study would provide a richer, more structured, and rigorous approach to data collection, interpretation and analysis, also providing an audit trail from data collection to interpretation and the development of theory.

Summary

The approaches used within this study were those proposed by Charmaz 2004, 2006, Parahoo 2006, Allan 2003 and Attride-Striling 2001 chosen for their emphasis on the use of techniques and procedures to develop theory. All researchers and participants are considered to have many views and opinions. Researchers bring these to their research. Their insider knowledge about a particular research area may allow and positively facilitate further in depth exploration of key areas which might otherwise remain inexplicit and unexplored. The researcher has a responsibility to make this knowledge, theoretical sensitivity and their particular experiences and views explicit within and throughout the research process. This is explored and expanded upon further within the next section. These approaches, along with the constant ongoing review of literature confer the benefits of theoretical sensitivity and provide the necessary framework to instil confidence in the researcher and in the overall conduct of the study.

Methods

The previous section provided background and discussion in relation to approaches and decisions around methodology. The aim of this section is to outline the methods, approaches and processes taken in conducting the study.

The case

Within this study, a case was defined as one health board area, but having elements of what Yin refers to as 'differing units of analysis' within it. The study was not just about exploring the defined case or health board and leaders' roles, but exploring the ability to try and distil events occurring within the case, and the wider world, for local understanding. This context cannot always precisely be defined but within this study was considered a concept that embraced everything outside an organisation or service. It was about national and local policy, the myriad of views of individuals, patient groups and politicians, plus the relationship

flowing from the inter-connected networks of organisations across health systems. Therefore, to some extent within this research the following were all considered: other health boards, the neighbouring immediate environment, sub units, the role of policy via such organisations as the Scottish Government, NHS Education for Scotland, NHS Scotland and other strategic bodies, and internally differing boundaries, organisational and professional.

Selection of cases / health boards

In line with approaches to data generation and analysis, to maximise the study's potential and the exploration of issues and problems in practice, this study employed the use of both purposive and theoretical sampling at different points within the study. In the selection of cases, the use of purposive and directed sampling allowed the researcher to select who and what to study, the sources that would most help to address the basic research aims and fit the basic study's purpose. Secondly it allowed the researcher to choose who and what not to investigate (Erlandson 1993). Personal and organisational success as a leader is heavily dependent on understanding context and developing successful inter-personal and inter-organisational relationships in order to move forward change (Northouse 2001, Alimo-Metcalfe and Alban-Metcalfe 2001, Schein 1985). Some of the key issues and factors associated include: a leader's sphere of influence; where the role sits within organisational structures; and how it is viewed in and by the hierarchy. Culture and context may be important in facilitating leadership behaviours and are often reflected in the structure of the organisation. Ways this can be viewed are through an organisation's approach to change and development, their investment in new leadership roles, and on how these roles are integrated into the organisation.

Choices in selection and inclusion for this study therefore were based on consideration of all these factors and included the ability to maximise understanding, knowledge gained from an extensive review of the literature and

from anecdotal experience. Information on health boards was available via the Scottish Government's website and via boards' organisational charts and information, often displayed in annual reports, available on local websites. Some discussion also took place with two to three key informers with key vantage points who were therefore able to provide additional 'soft intelligence' to inform case selection. This included discussions in relation to teaching and non-teaching boards, investment in leadership roles and differences in structure and organisational approaches. Pragmatic issues such as population numbers and travel were also considered.

In order to fully explore these issues in depth, to increase the range of data the researcher was exposed to, and to maximise the ability to identify emerging themes that take adequate account of contextual conditions and cultural norms, this research involved the study of more than one case or health board. Although boards/cases may be similar in many ways, involving those with differing structures, roles and approaches allowed greater depth of study. The gathering of more information concerning the phenomena under study therefore allowed the ability to provide a more rich focus, so that comparisons and meanings could be drawn in relation to two different but meaningful cases and situations. This study therefore involved two health boards/cases in Scotland. Two areas were chosen which depicted slightly different structures, approaches and roles. This included a teaching and a non-teaching board, differences in management structures and some differences in approaches to new leadership roles.

Ethical considerations

An application was made to the Scottish Medical Research Ethics Committee (MREC) in August 2006, which was reviewed and approved in September 2006 (Reference: 06/MRE10/70). In line with current research procedures, individual approaches were also made to each of the two health board areas with approval granted in January 2007.

Pilot Study

A number of informal discussions were held with a chief executive, director of planning and director of nursing in order to gain further thoughts on areas of importance and possible interview questions. These were carried out in a large teaching board similar in structure to the two health boards selected and therefore made a suitable testing ground for the study. The ready access to this board also made a pilot study feasible in the time available. Three pilot interviews were then conducted with one member of the board's executive management team and two senior nurse leaders. The aims of these were: generally to discuss areas for exploration; specifically to ascertain and assess the depth and accuracy of information received; practise qualitative interviewing, recording and note taking; and for the researcher to receive feedback on the format of the interview and question areas. Data collected were not included in the study but were simply used by the researcher to inform the main study. Following the pilot study a number of logistical changes were made, notably to increase the time allocated per interview and one or two questions were reworded to aid clarity. It was also decided to engage the use of a contact summary sheet as suggested by Miles and Huberman (1994) to summarise and capture any initial salient key points and any thoughtful reflections and impressions immediately following completion of each interview.

Selection within each case / health board

Following reflection, discussions and the pilot interviews, as this study was about exploring each case as a whole, the context and culture, as well as exploring leadership behaviours within it, it was decided to approach the study in three phases. The main reasons for this were; firstly, to establish a possible contextual and exploratory phase which would then set the tone for further data collection; secondly the feeling by the researcher that different leadership styles and behaviours may be displayed and required at different levels within the organisation, so perhaps warranting separate discussion. Also methodologically the researcher aimed for a process based on reflection and inductive design which was

primarily driven by data collected. Within the literature reviewed the few studies already conducted within nursing had explored top management levels only, and what is now known is the importance of asking followers their experiences of leadership styles (Alimo-Metcalfe and Alban-Metcalfe 2001). It was therefore decided to conduct the study at a number of different levels within each organisation, with a mixture of the board's executive management team, directors, nursing, clinical and non clinical staff. Therefore prior to sample selection for the first phase, conversations took place with each chief executive and director of nursing about structures and roles to inform selection.

The breakdown of the sample across both geographical areas was similar. All participants came from NHS backgrounds bar four or five who had experienced some years in the private or voluntary sector. Time in post ranged from six months to twelve years, with an average of three years.

Phase one

Experience well supported by the literature, suggests that there are key roles within any organisation that are influential in shaping its culture and context (Alimo-Metcalfe and Alban-Metcalfe 2003). This would be likely to involve, the chairman, chief executives, directors of finance, planning, public health and directors of nursing. Phase one therefore employed the use of purposeful sampling and consisted of eleven interviews with clinical and non-clinical leaders in key strategic roles at executive and director level. Each participant had a distinct area of professional leadership and a large corporate portfolio. All managed a small team who were responsible for large groups of staff across the organisation. No participant had direct clinical care commitments and almost all described their role as providing professional leadership at executive level, with responsibility for leadership, change, redesign and development. Interviews in phase one also included questions on the general structure of the organisation and on how things were approached in order to enable the researcher to learn something of the

history and present functioning of the organisation, to gain a feel for the general overview of structure, and ascertain some thoughts around the context in which these roles function. This also helped to form some thoughts and ideas about the values of the organisation, how they do business, and what was considered important. It also involved reviewing and discussing organisational charts and generally walking around the organisation.

Phase two

Phases two and three involved a mixture of purposeful and theoretical and conceptually driven sampling and consisted of seventeen interviews with senior nurse leaders and nurse specialists, nine in phase two, and eight in phase three. Theoretical sampling has been defined as 'seeking pertinent data' (Charmaz 2006:96). It assists the researcher in the ability to go back and forth between thinking about the existing data and generating new strategies for collecting new data. The emphasis is on obtaining multiple perspectives. Key leadership roles traditionally in nursing have been considered to be the director of nursing and lead nurses/managers. Over the last decade and following implementation of government changes and policy, this now involves roles such as lead and practice development nurses and nurse consultants, in more distributed leadership models and approaches. Key expectations around leadership and leadership behaviours have been attributed in policy to all of these roles (SEHD 2005a) but actual roles, remits and functioning differ across most health board areas. Initial conversations and the first set of interviews helped to map out where the principal sources of data existed within each case. These included those in traditional nurse leadership roles such as those listed above, but also included those in newly established leadership roles, and a number of posts working at ground level.

Employing theoretical sampling, a second set of interviews was then conducted with a sample of four to five senior nurse leaders in each health board area. Sampling for the study therefore was driven by literature, policy and the interview process

itself. Opportunities were taken to build on views and participants' advice and recommendations, as to additional discussions and interviews. Phase two consisted of senior nurse leaders often with many years of clinical and managerial experience. All were responsible for clinical services with no hands-on clinical work although all described their role as 'clinical'. Most had managerial responsibility for a number of portfolios across the organisation as well as their own particular specialist area and most managed large groups of staff.

Phase three

In phase two of the study all respondents were asked to nominate a present and/or a potential leader from within their area of responsibility. This could have included any nurse leaders and was not necessarily hierarchical. Each respondent was asked to provide the researcher with a paragraph either verbally or in writing outlining why they had chosen the people nominated and to give details of the particular qualities they felt identified them as a leader or a potential leader of the future. Reasons given by respondents for selection were similar and correlated with the attributes listed and expected of a nurse leader within this study. Three out of the four participants in each area had specialist portfolios, such as long term conditions, respiratory care, or cardiology, and three quarters managed staff. All strongly emphasised the importance of the clinical elements of their role, describing their posts as clinical, but only two actually provided direct patient care. Following receipt of nominations from each participant in phase two, the third and final set of interviews were arranged, completing phase three of the study.

Data generation

The case studies were built on one-to-one semi-structured interviews, conducted in total with twenty eight senior leaders and nurse leaders, in three phases, across the two Health Board areas. Phase one included key roles such as chief executives, chairman, executive and clinical directors. Phase two included director level managers and leaders, middle managers and senior clinical leadership posts such

as nurse consultant. As phase three was nominated by participants in phase two, this included a mixture of senior leaders, specialist leadership roles and practice development posts. These are all roles where anecdotally and highlighted in the literature and policy we would expect to see a demonstration of leadership behaviours within nursing and the organisation. Interviews lasted approximately two hours, and took place within the health board area, at a site suggested by participants. Time also allowed additional discussion and walks round the area to establish context and learn about the culture and environment.

Initial approach was made via e mail with a letter outlining the study and suggested process together with an information sheet. Prospective participants were asked to contact the researcher directly if they would like to take part. No respondents were followed up, and all respondents contacted the researcher after the first initial approach. Following initial confirmation of the wish to participate, each participant was then contacted in writing outlining agreements and procedures. Some provisional personal details were recorded, such as participants' backgrounds and length of service. Interviews were arranged one per day, allowing time for reflection and analysis prior to the next.

Taking the phased approach outlined, interviews were completed with the researcher moving between the two cases, allowing exploration of key issues emerging, and reflection and analysis of any differences between the two areas. Each phase was completed prior to approaching and completing the next, the intention being that one phase informed the next. Interview questions were adjusted after each interview. Based on the literature, experience and discussions, initial questions were formed covering six broad areas; background and definitions; working in the NHS; discussions around the individual case; leadership; culture; leadership in nursing, and personal thoughts and experiences. An outline of the initial topic guide and possible questions are provided in Appendix 1. Both the Chief Executive and the Directors of Nursing in both board areas requested to be

kept informed of intended processes and courses of action throughout the study. Data generated within the interviews where appropriate were enriched with data from documents such as job descriptions, minutes of meetings and via some non-participant observation, providing additional background and contextual information, although due to time constraints this was limited. This information was accessed via websites, through discussions with managers and following discussions within interviews. Both field notes and a reflective diary were kept by the researcher, detailing interview notes and notes of the environment and general observations. A table of participants illustrating their level and role in the organisation, which case they belonged to, the sequence or phase in which they were interviewed is set out in Table 3.4 below:

Table 3.4: Table of Participants

Case one		***Case two***	
Phase one N = 6	Director level and above. Two participants came from clinical backgrounds, three from administrative backgrounds and one from organisational development.	***Phase one*** N = 5	Director level and above. Three participants came from clinical backgrounds and two from administrative backgrounds.
Phase two N =5	Three participants were senior nurses and two lead nurses	***Phase two*** N =4	Three participants were senior nurses and one a lead nurses
Phase three N - 4	Three participants were lead nurses and one a specialist nurse	***Phase three*** N - 4	Two participants were senior nurses, one a lead nurse and one a specialist nurse

**** Definition of terms***

Senior nurse*: incorporates associate director level, nurse consultants and roles with large corporate portfolios.*

Lead nurse*: incorporates senior roles but are roles which are more locally located within a service, for example part of a CHP or a particular directorate or are a professional lead role.*

Specialist nurse*: A mixture of corporate and local portfolios but participants are leaders for specific key areas such as long term conditions or cardiology only.*

All participants were both leaders and followers within differing contexts. The level and role are presented as generic categories to preserve anonymity within cases.

Interviews

Interviews formed the main data collection tool within this study. Interviews in case study research are used to explore and probe in depth particular circumstances of the organisation, and the relation between organisational behaviour and its specific context (Yin 2003, Mason 2002, Pope 2006). They help the researcher to understand and put into a larger context the inter-personal social and cultural aspects of the environment (Erlandson 1993). Case study methods therefore, are likely to be better able to adapt to and probe areas of original but also emergent theory (Cassell 1999). More economical than other methods, researchers can also use an interview to find out about things that cannot be seen or heard, such as the interviewee's inner state, the reasoning behind their actions and feelings (Charmaz 2004, 2006). This study was interested in exploring both explicit knowledge (what respondents can explain or how they know it) and tacit intuition, (where respondents may feel or sense something, often very strongly but are hard placed to explain or justify it). This can also perhaps be articulated as unwritten assumptions, the how and why things are, how people feel about them or

explain them, shared and constructed meanings of things and how people make sense of circumstances and events. Therefore, this research aimed to seek out and present multiple perspectives of activities and issues discovering and portraying the different views.

Most commonly case study interviews are open - ended in which an investigator can ask respondents for the facts of a matter, as well as for opinions about events. This open ended informal interviewing process is similar to, and yet different from, an informal conversation. The researcher and respondent engage in dialogue in a manner that is a mixture of conversation and embedded questions (Charmaz 2006, Yin 2003, Mason 2002).

Interviews are much more than just a tool, but a way of bringing together multiple views of people (Kvale 1996). Schostak, (2005) regards the interview as the space between views, not the views themselves, and forms conclusions for critical reflective dialogue to emerge. In naturalistic research interviews take more of the form of a dialogue or an interaction. Dexter (1970) describes interviews as a conversation with a purpose. Interviews allow the researcher and respondent to move back and forth in time, to reconstruct the past, interpret the present and speculatively forecast the future (Lincoln and Guba 1985). Interviews also help the researcher to understand and put into a larger context the interpersonal social and cultural aspects of the environment. Interpretivist reactions to quantitative methodology in the 1960s and 70's (Seale 2002), argued that what people said in interviews and questionnaires was not necessarily what they did in practice, and this is an argument that could be levelled at all interviews, but was felt to apply particularly to scheduled standardised formats. Here, researchers typically meet the interviewee only once, trust therefore not being well established, and interviewees are unable to talk about topics not on the interview schedule. This was seen as generating a degree of alienation in interviews from the aims of the research, increasing the propensity to give misleading replies. To avoid this, steps

were taken in this study to try and achieve a balance between having a broad topic area with specific questions, and ensuring interviews were semi-structured and flexible. During the interview, spontaneous questions, follow ups, probes and signs to encourage and allow speakers to continue speaking were used allowing participants to say how they saw things in their own words, rather than follow the researcher's agenda. Thus the interviewer's role was non directive.

The interview process therefore was inductive, with leadership behaviours under study drawn inductively, through discussion and exploration with people in the field, in an attempt to generate what they understood by leadership, and to draw out tacit knowledge and understanding about how these play out in practice. This was also done in conjunction with the development of some tentative deductive propositions and assumptions, drawn from an extensive reading of the literature and policy which allowed, to some extent, the development of some key areas to be explored which were used as a basis to explore and build theory. These included: contextual issues, leadership styles and behaviours, roles and remits, how things happen in practice, change and change management. From a nursing perspective the increased significance of a grounded theory approach is that it allows for the elucidation of personal experience. That is to say that grounded theory will be sensitive to the advancement of participants' subjective experience because it is grounded in their accounts of assessments and situations. This study asked how nurses and non nurses construct their understanding of leadership and leadership behaviours in practice. To achieve this level of understanding participants are required to talk about their experiences in context and in ways that make sense to them. This may be achieved by the grounded theory approach, where participants are often afforded space to recount events through the facility of the in depth interview (Coyle 1997).

Other empirical sources

Interviews and observation build understanding of a social context in an interactive way (Erlandson 1993). For this reason, the researcher cannot treat these two sources of data as independent of each other. Through observations, the researcher can gain a particularly independent view of the experience in which respondents construct realities. The interview provides leads for the researcher's observations, and observation suggests probes for interviews. The interaction of the two sources of data not only enriches them both but also provides a basis for analysis that would not be possible with only one source. Observation like interviews can range from very focused to unstructured forms (Erlandson 1993). The main intention for use in this study was for observation to be used as a supplementary technique, to give some additional illustrative dimension and different types of evidence, and cross validity to support the main method of interviews. There are three main elements to observation: watching what people do, listening to what they say, and sometimes asking them to clarify questions and answers (Erlandson 1993). The overpowering validity of observation is not what they say they do, but what it is they actually do. In reality due to time constraints any actual observation undertaken was limited and was confined to observations of various interactions in corridors or meetings or by observing conversations on the phone. In relation to observing culture and environment, field notes were taken which formed part of the documentation and final analysis and provided additional areas to be pursued in interviews.

Documents also constituted a third source of evidence, although as with observation, the main aim of its use in this study was to provide additional supplementary evidence which assisted in contextualising information and data gathered within the study. Selection of these was guided by information gathered in general discussions and by interview. These included organisational charts, minutes of meetings, job descriptions, proposals and bids, and developmental / training plans and activities. The term document refers to the broad range of

written and symbolic records, as well as any available material and data. The data obtained from documents was used in the same manner as those derived from interviews or observations. The search for documents was guided by the researcher's emerging design. Merriam (1988) notes that it is a flexible yet systematic process that allows the researcher's hunches and tentative hypotheses to serve as guides in the 'accidental' discovery of valuable data.

Handling the data

With the consent of participants, all twenty eight interviews were tape recorded. This was supplemented by notes made during the interview by the researcher and brief field notes made after each interview. All tapes were fully transcribed ready for analysis in conjunction with the researcher's notes and any documentary or observational literature. Case studies were conducted on the basis of anonymity and that the identity of each health board would not be disclosed and any comments would not be attributable to individuals. Interviews were conducted on the basis of confidentiality. All respondents and transcripts were assigned a code known only to the principal researcher. Comments were not disclosed to anyone other than the research team and were used solely for the purposes of producing anonymised data. Also considered was the possibility of participants identifying other colleagues from within the case, either through knowledge of others participating in the study or by the identification of attributable comments and phrases. A range of strategies was used in ensuring the data concealed the identity of individuals. These included; the presentation of limited information on each case and the use of generic titles when referring to individual respondents such as lead nurse, middle manager, executive team member which could reflect a variety of individuals in any health organisation.

Presenting the data

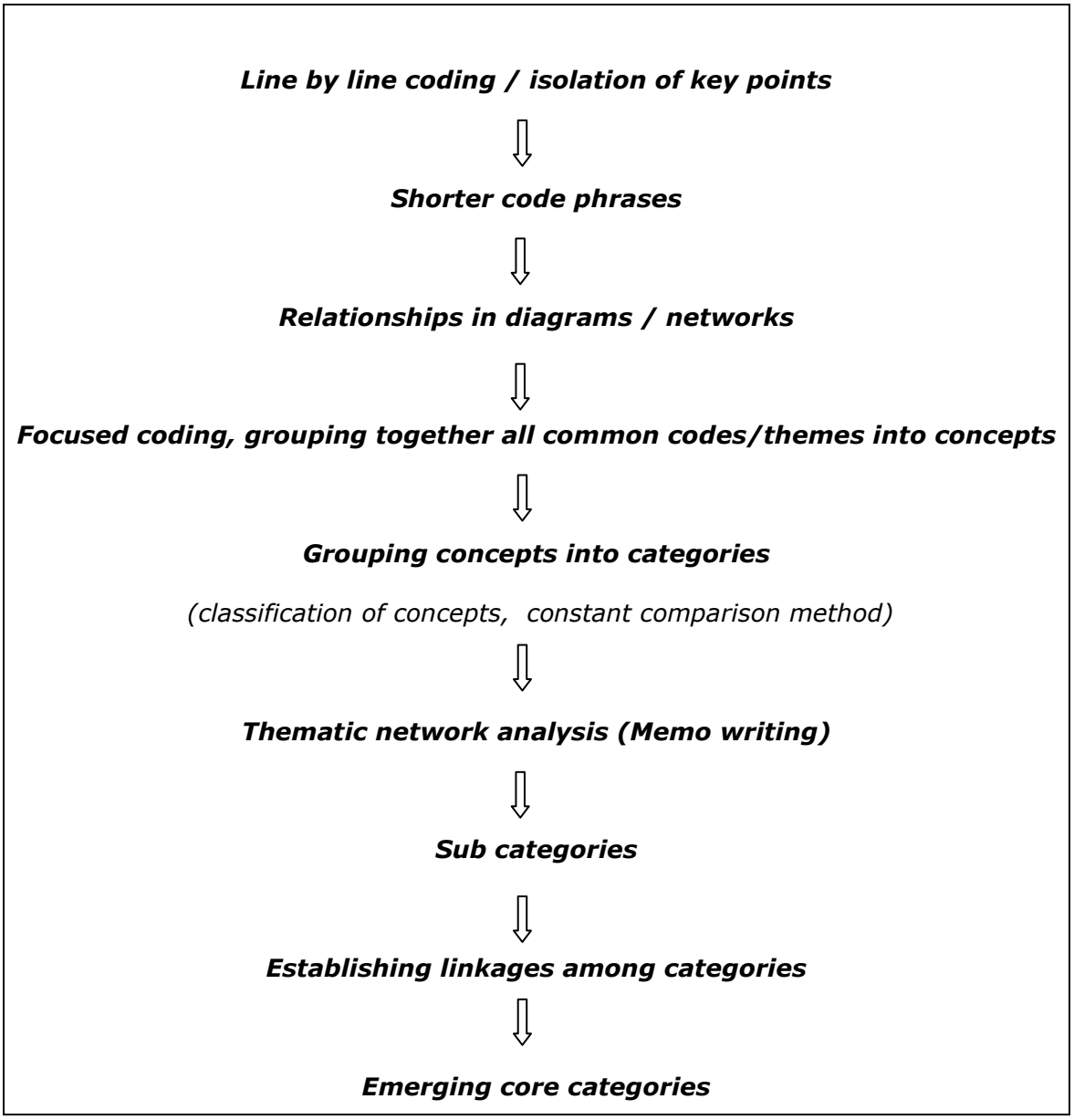
Qualitative research is about looking for the emergence of meaning. Within this research it was to understand behaviours, issues and contexts with regard to two

particular health boards and direct interpretation, trying to find significance, through asking what does that mean, and then re-interrogating the data for evidence critical to assertions. The aims of data collection in line with qualitative approaches and methods were to try to maximise the gathering of what is termed by (Lincoln and Guba 1985) as 'thick data', that tries to capture the phenomena being studied and its related issues, and that seeks to demonstrate the inter-relation with their context.

Reading supporting literature and other discussions stimulated ideas as the interviews progressed regarding what issues to pursue in order to uncover factors important to the development of emerging theory. Grounded theory literature suggests that theoretical sampling is cumulative with the researcher generating as many categories as possible in the early stages of the analysis (Charmaz 2004, 2006, Strauss and Corbin 1990). Strauss and Corbin also promote flexibility when sampling with the researcher able to respond to and pursue areas of investigation that may not initially be apparent but may arise as the investigation is underway. Each interview provided more information and added greater density to the emerging understanding of how nurses perceive and understand leadership and questions were constantly refined and reworked. In line with the methodology outlined previously (Charmaz 2006, Allan 2003, Attride Stirling 2001), the process involved the researcher developing a coding frame, (see Appendix 2), manually taking each interview transcript, highlighting substantive key words and statements, and deriving a set of concepts, networks and categories, for the responses to each question, and in which to place behaviours or processes (Yin 2003). Within this study, coding was left quite broad, with categories developed based on the data, but with attempts made to avoid categories becoming too narrow in focus. Negative instances were also searched for that may have contradicted or helped to develop an emerging theme. Representative quotes were also selected to be included in the final report. The use of systematic coding and subdivisions, so that categories began to develop branches was utilised, as outlined

by Seale (2002), which can help in improving the validity of reports of qualitative data by presenting counts of how many times, and in which circumstances a thing happens. In analysing interview data emerging categories, conditions, context, action or interactional strategies and consequences were considered as part of the process of coding. As grounded theory is a continually evolving process diagrams cannot present a completely accurate reflection of the analytical process although can be helpful in providing an overview. Figure 3.1 demonstrates the basic processes undertaken in the analysis of interview data in this study beginning with line by line coding and the isolation of key points.

Figure 3.1: Outline of analytical process



Key phrases in the respondents' own words were captured and used to develop the main ideas which emerged as the interviews progressed. For example line by line coding identified phrases such as: *"I've been in the NHS for twenty four years and the last few years I've had more and more national orders, prescriptions, instructions than ever before"* [1] which were constantly compared with new data until categories were formed, for example , 'Leadership in the NHS'. As other categories were identified they were constantly compared with each other and where links or differences were identified these formed sub categories which was aided by the use of diagrams and network analysis. As analysis progressed subcategories were examined in detail to identify their characteristics, properties and dimensions. Finally linkages were made between subcategories to allow for conceptual order to be placed on the data which gave rise to the development of core categories used to build theory. A core category being defined by Strauss and Corbin (1990) as the central phenomenon around which all the other categories are integrated.

Using the developed framework, constant comparative analysis between data, codes and categories and coding procedure, theories were developed around several core categories (Strauss and Corbin 1998, Charmaz 2000, 2006), with care taken to constantly reflect back to the data, to avoid codes becoming divorced from the social context. Also at this stage, the researcher tried to reflect on the meaning of what was happening in each case, explanation, impressions, using thoughts around the geographical context, demographics organisational charts, showing key actors and relationships. Any current innovation, planning or implementation of key relevant initiatives was also taken into consideration.

As there may be several different threads in a study several core categories may be identified in any given set of data. In line with constructivist grounded theory the researcher was open to having a number of core categories with a combination of

[1] Respondent N2P1C1-(ET)

views and interpretations. Therefore in describing the core categories many extracts from the interview contained and made reference to more than one of the core categories. For example contextual factors were readily identifiable in descriptions of nurse leadership yet whilst describing these, aspects of the nursing profession and nurses personal values were also identified: *"You almost have to tick the boxes that need ticking before you can do any of the other stuff... now... there's no strive to do post graduate education and if there is it's by the ones who are told that they are doing it."* [2] This is a natural consequence of allowing respondents to freely describe issues rather than impose set questions and structures. One example illustrating use of the coding framework and process of analysis is provided in Appendix 3.

Data were analysed after each interview and then analysed and repeated across the first phase. The process was repeated in phases two and three. Twenty eight interviews were completed before no significantly different data was considered to be emerging. Using this framework and constant comparative analysis across all three phases, and finally across both board areas, theories were developed around five–six core categories. The final analysis of data led to the identification of the same five core categories across both board areas. A timeline illustrating.the relationship between the literature review, methodology, when the interviews took place and how these relate to the development of the overall study is presented on page 144.

In case studies interest centres on the uniqueness of cases, commonality and differences and in how they feel and function. Within this study as data analysis progressed and categories were formed it became apparent that there was little if any unique case specific data. Despite the two areas having very different geographies, structures and management styles any distinction between the boards

[2] Respondent N10P3C3-(SN)

was not significant, with more similarities than apparent differences, which in contrasting them you would have intuitively expected. The case could therefore more appropriately be defined as being the NHS in Scotland. The only noticeable difference between the two geographic areas was observations by the researcher regarding culture and climate and this is commented on within the appropriate section. It was decided therefore to write up the analysis, results and discussion as one qualitative study centred on the five core categories developed across the two board areas as set out:

1 Exploring leadership in the NHS

2 Leadership characteristics, styles and behaviours

3 Leadership roles

4 Nurturing and developing leadership

5 Leadership, organisational culture, environment and context

At each point in the data analysis process efforts were made to ensure that the integrity of interviewees' views and accounts was retained. Data were handled in an attempt to bring to the fore the shared and collective views of respondents. Views presented in the findings and discussion chapters therefore are the shared views, perceptions and beliefs of these informants.

Timeline

Literature review July 2004 - 2006

Developing methodology	- Jan - July 2006
July - Dec 2006	- Refining methods and developing interview schedule
Selection of cases	- Dec 2006
Jan 2007	- Letters to Chief Executive officers
Letters of invitation to participants	- Feb - April 2007
May - Sept 2007	- Phase one interviews
Ongoing data analysis	- May - Sept 2007
Sept 2007 - Feb2008	- Phase two interviews
Ongoing data analysis	- Sep 2007 - Feb 08
Feb - May 2008	- Phase three interviews
Data analysis	- Feb - May 2008
May 2008	- Interviews complete
Final data analysis	- May 2008 - Aug 2008
Aug 2008 - Dec 2008	- Final organisation of categories
Begin write up of findings	- Jan 2009
May 2009	- Second iteration of findings

Completion of thesis December 2010

Approaches to rigour

Different research paradigms make very different assumptions about reality, objectivity and generalisation. A number of methodical issues arise from these differences, and in views about the purpose and nature of both case studies, and grounded theory which have been subject to considerable debate.

Qualitative research and particularly grounded theory methods, acknowledge the role and influence of the researcher in terms of background, values and role, and do not claim either neutrality or authority, acknowledging that both researchers and respondents make assumptions about what is real, and have knowledge and experience which shape and influence their views and actions. Nevertheless, researchers need to be reflexive about what they bring to the study, what they see, and how they see it. Lincoln and Guba (1985) point out objectivity is an illusion. To try to maintain it, whilst studying human interactions is an exercise that fails to safeguard the data from the researcher, while inevitably serving as a barrier to prevent the researcher exploring the most relevant aspects of the data. The naturalistic paradigm builds on this, affirming the natural influence the researcher and respondents have on each other. There are issues of bias and reactivity, but also of being isolated from the data.

Strauss and Corbin (1990) believe that grounded theory should produce theory which is faithful to the everyday reality, and as such, should be comprehensive, and make sense to those who contributed to the study. Guba and Lincoln (1994) suggest four criteria demand attention and these are described as credibility, dependability, confirmability and transferability/generalisation. In order to promote rigour in this study, as well as ensuring that theory was grounded within the data, and depicted everyday reality, the criterion identified by Guba and Lincoln (1994) were applied. Demonstration of the relationship between the approach adopted, and the study findings was promoted in the following ways:

Credibility

A central question for any inquiry relates to the degree of confidence the findings of a particular inquiry have for the subjects with which, and the context within which, the inquiry was carried out (Lincoln and Guba, 1985:290). Within the research paradigm this relates to the compatibility of the constructed realities that exist in the minds of the inquiry's respondents, with those that are attributed to them. This relationship is termed credibility (Erlandson 1993).

A grounded theory approach begins with the establishment of the research question and the collection of data, and may be said to be dependent upon the accuracy of source data. Source data in this study refers to both the pilot and the first phase of interviews conducted. This source data provided both the information required to undertake purposeful sampling for interviews, and to assist the researcher to develop a semi-structured approach to in-depth interviews. Although expectations for grounded theory studies vary, Charmaz sets out useful criteria to ensure rigour, and to test questions and approaches, and this was also adopted and utilised within this study (Charmaz 2006: 18,20,21).

The major concern in establishing credibility is interpreting the constructed realities that exist in the context being studied. Because these realities exist in the minds of the people in the context, attention must be directed to gaining a comprehensive intensive interpretation of these realities that will be affirmed by the people in the context. Guba and Lincoln (1994) point out that the credibility of an inquiry involves two aspects. Firstly, that the study is carried out in such a way that the believability of the findings is enhanced, and secondly, that identifiable steps are taken to demonstrate credibility. Lincoln and Guba have proposed a series of strategies for accomplishing this which include prolonged engagement, triangulation, researcher credibility and member checks. These concepts are now discussed with reference to this study.

Prolonged engagement

Prolonged engagement is said by Kirk and Miller (1986) to enhance sensitivity to any discrepancies between meanings, presumed by the researcher and understood by the target population. It also ensures that the researcher will maximise the opportunity to identify certain characteristics and elements in a situation which are most relevant to the issue being explored, and to focus on them in more detail (Guba and Lincoln 1994). In this study this was enhanced by the inclusion of certain strategies within data collection and analysis including, the use of digital recording, the documentation of non verbal cues and changes of voice, or emphasis within the interviews, observational notes of particular feelings and issues, together with timely analysis of transcripts and field notes.

Triangulation

When looking for congruence triangulation is often used to gain and interpret multiple perspectives about a phenomenon. Denzin and Lincoln (2000) identify four types of triangulation: data, investigator, theory and method triangulation. The decision to utilise two cases within this study would allow the collection of data across two potentially separate and different samples and would provide an attempt to potentially validate data through multiple perspectives. The use of both theory and investigator triangulation, was felt not to be helpful and/or not consistent with the grounded theory approach used within this study. However triangulation was considered to be an important construct of the overall desire to demonstrate credibility of the research and the research process. The use of a three phased approach within the study, and the development of the initial exploratory first phase, together with the in-depth interviews, provided an opportunity for the researcher to develop a comprehensive understanding after the initial in-depth first phase data collection and analysis. It also allowed the researcher to use the results and discussions in determining participants for the second and third phases of the study. Therefore credibility was enhanced by the use of a clear structure leading to purposeful sampling.

Researcher credibility

This according to Patton (1990) refers to the faith that can be placed in the researcher. Within the study, care was taken to ensure accurate use of terminology, and the study was constructed in such a way that participants would recognise their reality. Grounded theorists and proponents of naturalistic paradigms, function within a framework, in which the researcher assumes that interviewees provide information that they feel is both truthful and accurate. Care was taken to ensure a clear structured path to sampling, promoting transparency of approach. Grounded theory allowed the researcher to have an open mind about data because a hypothesis was not proposed, and the use of detailed coding strategies, meant the researcher was able to thoroughly examine data and build theory which was grounded in the data. Use of representative quotes and presentation of findings in interviewees' own words and narratives allowed accounts based on respondents' actual views and interpretations.

Member checks

External checks include strategies such as respondent validation, and peer debriefing. These are processes by which the accuracy of data may be checked by those who have provided it, thus increasing credibility. However some researchers approach this with caution, (Charmaz 2006, Mason 1996), and note that participants may not recognise field notes or verbal clues that have been included, or just may not recall bits of conversation. A further criticism could be that data is the researcher's interpretation, and therefore one cannot exclude the introduction of bias. However, within this study, in utilising grounded theory and a constructivist approach, this was felt to be in line with the overall philosophy of the research and process. Within the study, care and time was taken during each interview to replay back notes and conversations with each of the respondents, to check accuracy of notes and interpretation at that initial stage. Opportunity therefore was provided for participants to offer comments on whether or not they felt the data was captured in a manner congruent with their own experiences.

Sometimes case study research is advocated on the basis that it can capture the unique character of a person, situation, or group. Here, there may be no concern with typicality in relation to a category, or generalisability to a population. The aim is to represent the case authenticity in is own terms, and to capture the unique voices of those people and perspectives. Questions are raised here within the literature, around links with constructivist models and naturalistic inquiry, regarding the ability to ever be able to represent wholly a group, one perspective, and or situation, independent of the researcher. Within this study the aim was to gather rich data. Methods were used to extend and modify views, and to broaden and deepen what we understand and learn from it. The aim was to see the world as the research participants do, not to replicate their views, but to try and enter their settings and situations to the extent possible.

Dependability

Guba and Lincoln state that "dependability is parallel to the conventional criterion of reliability, in that it is concerned with the stability of data over time". (1994:242). In this study, care was taken to conduct all interviews in the same manner, allowing the same timescales and preparatory phases to avoid any inconsistency or variation.

Confirmability

Confirmability may be described as ensuring direct and documented evidence taken from primary sources (Morse 1996), and as an audit trail which may include the use of filed notes, transcripts, diaries and data analysis. Within this study, both the use of grounded theory and thematic network analysis were utilised, both for their structured approach, but also for their use of memos and diagrammatic networks, to promote transparency and explanation, as the researcher moved through data analysis.

Transferability / generalisation

Guba and Lincolns framework (1994) describes transferability as the ability to transfer the findings of research to other studies or groups. Within the naturalistic paradigm, generalisation across social settings depends on aggregation of data, a practice that often ignores the context and specific inter-relationships that give those data meaning. Proponents of naturalistic inquiry realise the impossibility of generalising, and settle for a deeper understanding of social phenomena, as they are observed in their own contexts. In this study therefore transfer of understandings across social contexts depends on the degree to which thick descriptions of one set of inter-relationships in one social context allows for the formulation of 'working hypotheses' that can direct inquiry in another (Guba and Lincoln 1981). As highlighted, naturalistic inquiry is very dependent on context, and context binds together participants and people which results in mutual simultaneous shaping.

This complex web of inter-relationships provides a context that at one time both restricts, and extends the applicability of the research. On one hand, generalising to other settings is impossible because no two contexts are identical, and attempting to generalise about one phase of the context to other settings, ignores the unique issues that exist in each context. On the other hand, the intricacy of the context revealed by naturalistic inquiry, permits applications to inter-personal settings that are impossible with most studies, that follow more traditional research strategies. A comprehensive understanding of context enables us to make useful judgements about similarities and differences in context. As Erlandson (1993) says, context provides great power for understanding and makes predictions about social settings. Interpretation, therefore, is both limited and enriched by context.

Case studies are generally not concerned with generalisability, with the main concern being to understand the case studied itself, with no interest in empirical generalisation or theoretical inference. Within case study research, interest is in

developing theoretical ideas, not seeking explanation but greater understanding. Case studies are therefore considered only generalisable to theoretical propositions and not to populations. Their goal is to expand and generalise theories, analytical generalisation (Yin 1994) or naturalistic generalisation or transferability (Gomm 2000, 2000b, Stake 1995).

In some case study work, the aim is to draw or provide the basis for drawing conclusions about some general type of phenomenon or about members of a wider population of cases. Some argue that this is a kind of inference or generalisation that is very different from quantitative study (Yin 1994). Others suggest that there are ways in which case studies can be used to make what are in effect the same kinds of generalisations as those which survey researchers produce (Schofield 1979). Others argue that case studies need not make any claims about the generalisation of their findings, and that they fit into the processes of 'naturalistic generalisation' (Stake 1994), or to facilitate the transfer of findings from one setting to another on the basis of fit (Guba and Lincoln 1989). Gomm (2000) brings together a range of key articles dealing with case study research, and especially with its capacity to produce general conclusions. Some of the chapters, those by Stake, and Lincoln and Guba suggest that this is unnecessary or impossible, arguing in favour of 'thick description,' naturalistic generalisation, or transferability. Others, those by Schofield and Gomm *et al.*, suggest that case study research can provide the basis for empirical generalisation, and they outline some of the strategies for doing it, and some of the problems involved. Concern in this study was in identifying the essential theoretically conceptualised processes embodied in a case, rather that representing it in its uniqueness, or using it as a basis for wider study type generalisations (Gomm 2000).

According to Stake the great strength of case studies is that they provide 'vicarious experience' in the form of full and thorough knowledge of the particular. In doing this, they facilitate what he calls 'naturalistic generalisation' and thereby build up

the body of tacit knowledge on the basis of which people act. He argues, therefore, that case studies have general relevance even though they may not provide a sound basis for scientific generalisation of a conventional kind. However, if it is to be of value to people, it needs to be framed in the same terms as the everyday experience through which they learn about the world first hand. Within this study the main interest was on the uniqueness of cases, commonality and differences and how they felt and functioned. The aims were therefore by way of both interviews and observation to gain as deep an understanding as possible of current leadership behaviours in the NHS and how some of these behaviours may or may not be influenced by context. Care was taken to ensure the use of methods that were flexible and context specific.

Whatever the viewpoint, theories are rhetorical and thus present arguments about the world and relationships within it. Charmaz's preference is for 'theorizing', not for theory in the interpretive tradition. She views theorizing as a practice which entails the practical activity of engaging the world and of constructing abstract understandings about and within it. The fundamental contribution of grounded theory methods therefore resides in offering a guide to interpretive theoretical practice, not in providing a blueprint for theoretical products and this was the stance adopted within this study.

Theoretical sensitivity

One of the most important characteristics of grounded theory is the recognition given to, and importance placed on, theoretical sensitivity (Glaser 1978). Theoretical sensitivity refers to the ability to recognise what is important in data, and to give it meaning. Therefore it is something that the researcher brings to the research process as an individual. Theoretical sensitivity may refer to the personal qualities of the researcher, for example their perception and degree of scepticism driving the manner in which they analyse data. The application of theoretical sensitivity is said to indicate an awareness of the subtleties of meaning within data.

It refers to the "attribute of having insight, the ability to give meaning to data, the capacity to understand it, and the capacity to separate what is pertinent from what is not" (Strauss and Corbin 1990, 1998). For example, the researcher who thoroughly derives categories from the analytical process and validates them systematically displays theoretical sensitivity. Theoretical sensitivity does have a creative side, which may be displayed by the researcher who seeks to uncover hidden meaning in interviews, by the use of their interpersonal skills in an effort to explore data as fully as possible. The benefit of theoretical sensitivity is that it can aid rather than block theory development. This in itself displays the creativity and personal qualities of a researcher. To explore this it is important to consider how theoretical sensitivity may be developed and applied. What seems particularly important is that the researcher makes explicit the theoretical sensitivity being brought to the study as highlighted by Strauss and Corbin who describe theoretical sensitivity as coming from a number of sources, the personal qualities of the researcher being only one. These include personal and professional experience and the literature, technical and non-technical.

Researchers' backgrounds, assumptions and disciplinary perspectives alert them to look for certain possibilities and processes in their data, and shape conceptual emphases. These concepts can give ideas to pursue and sensitise you to ask particular kinds of questions about the topic. Awareness of the feelings which arise as a result of being in an organization and interacting with its members, can be helpful in managing those feelings (Hartley 1994), and efforts were made in this study to keep accurate and full records, diaries of events, and interviews. In this study, the researchers professional and personal experience is relevant, and was acknowledged as having the potential to increase theoretical sensitivity and knowledge and that insight may be drawn upon to the advantage of the study.

Whilst this study acknowledges the influence of the researcher on the research the researcher also needs to be aware of how they may influence perceptions and

interactions. Two areas in particular need to be discussed. Firstly, how interactions with and perceptions of the organisation / case affect the observations made and secondly how to attend to and manage the feelings which arise in the course of doing case study work, such as for example, concern, anxiety.

Within this study the researcher's experience was used not as a neutral participant, but positively to initially tease out and think through question areas, what information would be worth exploring, together with possibilities in relation to samples, access and approach. Having had experience of very poor leadership within nursing, the researcher had views about what areas would be worth exploring, and was interested in following all the emphasis recently given to leadership, in studying how things actually felt currently in practice, and perhaps to how leadership in nursing could be further developed and strengthened. As a practicing leader, the researcher already had a sound knowledge and practical understanding of the discipline and topic area. This provided vantage points, and an ability to quickly explore key areas central to the questions and argument in detail. Throughout the research process and interviews, the researcher was able to use anecdotal experience to shape and probe certain areas in more detail, ensuring more pertinent and complex data and engagement by participants in the process, which could not have been undertaken by an 'outsider' or someone with little or no experience of work or management in the NHS. In a number of cases the researcher gained impressions that certain discussions and disclosures were heightened by the researcher's obvious interest and knowledge of the area. As Charmaz articulates, sensitising concepts and disciplinary perspectives provide a place to start, not to end, and within grounded theory, these concepts are used as tools for developing ideas about processes they define in the data.

Summary

This study started with a view accepting that everyone has some preconceived ideas, perhaps not a theory, but concepts which come from a combination of

experience, views and literature and that these should be made explicit within the research. In adopting a naturalistic and case study approach to inquiry and to research design, it is recognised that approaches and methods are subjective and shaped by the researcher, relying heavily on our own previous experience and sense of reality. In adopting these approaches, it is acknowledged that as a result studies will be value influenced to an indeterminable degree. The aim of this is inquiry was the development of shared constructions and meanings. Others will therefore learn from what has been termed 'vicarious experience' that the study provides (Gomm 2000, Stake 1995, Erlandson 1993).

About the researcher

It is appropriate at this point to note my background and current role as a senior manager and leader within the NHS and a large health board in Scotland and how this enabled and influenced the study and research process. I am a nurse who has twenty seven years experience working in the NHS, the last fifteen of which have been in various senior management and leadership roles. Clearly I bring views, ideas, experiences and knowledge in relation to leadership, some of which underpinned my reasons for undertaking this study. Undoubtedly my position and experience played a significant part in establishing access for the study and in terms of how I was regarded and treated. I will return to this later in the discussion chapter.

Chapter Four

Findings

Qualitative findings from two health boards in Scotland

Introduction and review

The previous chapter explained the rationale behind methodological choices for the study, methods employed and analysis of data. This chapter presents the findings.

Introduction to the two health board areas

Scotland has fourteen geographically determined health boards which provide an integrated approach to commissioning and healthcare provision across primary and secondary care. Despite geographical differences boards are subject to the same policy context.

Both health boards selected have a significant number of acute hospitals, Community Health Partnerships (CHPs) and community sites across the organisation presenting challenges to service delivery, communication, leadership and management. Population numbers differ from around 800,000 in one with large urban areas to around 300,000 in the second. Total numbers of staff are substantial in both areas; the larger board employing around 28,000, 15,000 of whom are nurses and the smaller 8,000, 4, 000 of whom are nurses. As outlined in chapter three board accounts are necessarily kept broad to protect anonymity.

Within both areas investment had been or was taking place in various aspects of service development, which involved reorganisation and structural changes across

the organisation. In line with national guidance both had recently moved to new streamlined 'single system' models of working. This had involved particularly in one area significant displacement of managers and changes to roles and ways of working.

Within the smaller area a strong organisational development department existed which was utilising national leadership courses such as Leading Empowered Organisations (LEO), and the RCN Clinical Leadership Programme, across the organisation. Various in-house leadership courses had also been developed some of which were multi - disciplinary reflecting a strong emphasis on partnership working. Some investment had also taken place in the development of new leadership roles. Within the second and larger area considerable use had also been made of the RCN Clinical Leadership Programme together with the development of a number of in house leadership courses. Significant investment had also taken place in the use of private companies in relation to developing leadership and in discussing the establishment of cultural change. A particular project had also created a framework for 'how' roles are carried out in the organisation. This included behaviours and interactions expected with staff, patients, and the public. Aims were to create a shared set of beliefs on behaviour towards patients among NHS staff. Various specific training programmes had been developed to support the progress of this programme across the organisation, and attempts had been made to incorporate it within the RCN Clinical Leadership programme locally.

Presentation of findings

The findings are now presented, drawn from interviews in both geographical areas, under the five key headings developed and set out previously on page 132. Where data extracts are used codes and initials are provided attributing responses which categorise respondents into executive team (ET), senior nurses (SN), lead nurses (LN) or specialist nurses (SPN). In some cases actual titles differ from these but have been generically attributed to ensure anonymity. Key headings have been

developed where appropriate although it is important to note that none of these sections, categories or headings act in isolation and often these factors and issues run in parallel, acting in mutually reinforcing ways. This in some cases makes their separation and examination difficult. However the design and analysis chosen, together with findings across both cases, confirmed these as key issues and so they are presented separately, (as led by the analysis), and then explored in detail in their entirety in the discussion chapter which follows.

All findings presented are in informants own words and accounts; direct quotes and extracts are used, interwoven with a narrative that seeks to articulate the actions, interests, perceptions and views of study respondents. Even when not presented in direct quotes, this account is seeking to articulate the views advanced by study participants. Interpretations and discussion are left until chapter five.

Category One

Exploring leadership in the NHS

Introduction

Data within this category relate to interviewees' thoughts and feelings about working in the NHS, identifying particular difficulties and challenges and their effects on day to day practice. Views about how these issues affect approaches to leadership, leadership roles, organisational approaches and patient care are presented.

The "perceived challenges"

The main challenges to working in the NHS are identified as increased partnership working, expected levels of public scrutiny, the need for transparency, risk management, audit and targets, handling the media, and politics. In trying to summarise these and outline things that had changed an executive member said: *'it's the transparency, partnership and public scrutiny'* [3]. However difficulties arose when these were linked into the government's broader agenda, particularly clinical governance, audit and risk management and *'then there's the media and politics'*. Many emphasised the pressure of the wide spectrum of matters the NHS has to keep track of and deliver and the *'I want it and I want it now'* culture as referred to by one [4], and these together with the government's constant quest for new initiatives all of which need to be *'managed, planned, monitored and delivered in short timescales'*. It is said these can only be delivered *'if you've got infinite capacity'* and the reality is *'we've got restricted resources'*. They also need to be balanced with trying to enable front line staff to remain involved and as substantiated here: *"leaders are trying to bring in systems and processes which*

[3] N6P1C1-(ET)
[4] N6P1C1-(ET)

enable you to hold those pressures at bay while enabling front line teams to be enthusiastic and innovative." [5] The long term nature of achieving any change is emphasised with the NHS described by one respondent as being like a religion and: "*like all religions it doesn't deliver in the short term, at least not in our life time. So there is always a level of dissatisfaction in it."* [6]

Good leadership, management and communication are considered vital to effective working but a number of factors hinder effective achievement: the complexity of structures and variety of different groups of staff, the differing roles of professionals, and the effects of recent government reforms.

The "complexity of structures"

Respondents describe health boards as vast organisations with many intricate parts, many different forms of leadership, lots of differing specialities, such as medicine and surgery, but with cross over links that need to integrate to work effectively as one organisation. These specialities were thought by one to resemble a series of web-like cells similar to the 'al Qaeda' organisation. Respondents thought these complexities should lend themselves to the NHS functioning as a matrix organisation but that the approach taken to leadership and management in practice is often more like that seen in the army. Many noted differences between the public and private sector particularly with regard to interests and approaches, with the public sector being seen as a public service and private industry as serving stakeholders. Public service should focus on the beneficiaries of the service rather than on the government:

"Within the public service there's a particular need to demonstrate that whatever you are leading on is quite clearly in the service of somebody. In the health service it would be in the interest of patients but in the bus service it would be

[5] N6P1C1-(ET)
[6] N6P1C1-(ET)

passengers..... Conversely the private sector might have a customer focus but actually the leadership has to be in relation to the board or shareholders or something like external stakeholders. We don't have that, the public service don't have a requirement in that sense." *(N1P1C2 – ET)*

Respondents felt therefore that behaviours, characteristics and ways of working should relate to this service aspect and emphasised that a key characteristic of leadership in the public sector is the need to be very aware of patients and staff:

"You've really got to be able to connect with those who have to carry out whatever the leaders want to do, so that implies a more collaborative consensual approach." (N1P1C2 - ET)

A point strongly emphasised is that the complexity of the NHS is exacerbated by the existence of various 'tribes' all deciding their own agendas and priorities. In discussing these 'tribes' one respondent said *'some of them don't always think they are a part of the NHS'* and that this mainly applies to doctors: "*they work in the NHS but they don't think they do, they think about their patients and profession"*.[7] The number of different professional groups and staff is considerable all of which have different levers, priorities, objectives and personalities which make any unified approaches to management and leadership very difficult. Respondents said this brings additional challenges as historically the NHS is perceived to have pandered to different professional groups' views and needs. This respondent highlights such issues:

"*I remember reading an article on a corporation bank and they went through a whole restructuring process and they say it took them two years to get it completed and operating effectively. It takes us two years to actually do the same sort of thing and then it takes us another six months to actually do the same productivity*

[7] N2P1C1-(ET)

level, because we allow people to not participate properly. We allow them to have a degree of, do they 'want in', do they 'not want in' and that's really important as well." (N6P1C2 – ET)

Most professional groups would have a view on how specific issues may or may not affect them and a wish to be involved or consulted on any change. An executive member considered that consultants and some of the very senior nurses act almost like partners in a company like Price Waterhouse Coopers. They emphasise that: *"sometimes that's forgotten, and that level of contribution is not respected, and sometimes conversely staff forget it and behave badly."* [8] The NHS therefore is struggling with the fact that not everybody is equal, that everybody has to be briefed, everybody has to be respected, everybody has to be involved in the decisions but then also everybody has to get on and do the job. This combination of differing professional groups with differing levels of autonomy and different lines of accountability creates a further problem: various groups' reluctance to implement changes and initiatives. There need to be stronger hierarchical performance mechanisms and accountability:

"The health service has hundreds of things that don't work because people actually believe they can pick and choose what they support. I think we've brought back chief nurses who are more like matrons who give you that control mechanism and I think people and management structures need to be hierarchal in a big organisation such as this.... In a big organisation with the regulation and responsibility you need them." (N6P1C2 – ET)

A general point made was the NHS often has non-clinicians running it unlike the private sector where the person in charge would be someone with specific knowledge of that area. It was perceived that leadership should be from someone who has implicit understanding of that area and what's involved in order to get the

[8] N6P1C2-(ET)

best out of people and the service. Many outside the NHS often saw the NHS: *"as a facsimile organisation or as having some traditional classical economical model where knowledge and capital are kept to the top and where the moaning proletariat are blindly sweating away in the trenches at the bottom of the organisation."* [9] Respondents describe this model as being inverted with frontline professionals, a number of them educated to post doctoral level, and a disconnected hierarchy, which is increasingly disconnected as you go up or down the organisation depending on your model.

Fully realising and achieving leadership potential in the NHS is considered a challenge. Despite an agreed direction and approach in reality within any health board organisation and hierarchal structure there are often at least two or three other sets of influential leaders, all of whom may have different interpretations and styles. The implementation of strategy therefore often differs creating a lack of consistency across the whole organisation. What is considered crucial is that leadership is required at every level of the organisation with attention needing to be paid by leaders to ensuring and embedding specific organisational aims and values:

"We have a thing about ethical behavioural standards so they know what our obligations are and what their obligations are to us. It's like whoever runs a global business, you can't be in every part of it but you can cause the pulses that go up and down to at least be consistent and give people a sense they're working for somebody who actually cares about them." (N3P1C2 - ET)

The "differing roles of professionals"

Respondents feel professional groups such as doctors have a distinctive culture in the NHS where they have been allowed to decide if they are opting 'in' or 'out' of something which is unlike other organisations. To some extent recent reforms have

[9] N6P1C1-(ET)

increased expectations on the focus and direction set out by the government which in organisational terms has emphasised expectations on uniformity versus any opting in or out, but in certain professions such as medicine according to respondents there still appear to be issues when this rule does not apply:

"Medics are different: they don't really care, they don't come under the sort of hierarchy..... Nurses just know when to toe the line, whereas medics don't have to, so there is a difference. Doctors are brought up to believe they are special through the whole of their medical training.... their opinions are so very important, and they are important because everyone who works in the organisation is important but they can just do their own thing and they can just say that rule doesn't apply to me. There's still an inherent difference from how a nurse would be treated over something and a medic." (N11P3C2 - SN)

As highlighted by this respondent there appears to be a lack of ownership and involvement in the wider organisational agenda with many doctors not appearing to see this as their role:

"I think in terms of leadership it takes a really strong leader, like even [name of clinician] who is a big cancer guy and he's a good leader because you aspire to be like him, but I don't know how he would be in day to day management because medics don't really want to know about money. They don't bother about stuff like that.... they are busy being doctors and being political with a bigger P than bothering about the targets for savings. The doctors they just laugh when I say we've got a million pound crest target, 'ha ha I'm sure you'll do it..... whereas if I say to my staff we've got a million pound crest target what can we save, they will actually engage." (N11P3C2 - LN)

The power base at board level is felt to be the medics: *"when you look at the power base of who is on the board, it's medics again"* [10] and some comment with interest on the amount of discussion and debate that takes place at board level in relation to medicine. The point is made that this discussion does not take place regarding nursing:

"It is interesting because the amount of debate that goes around the AMC contracts and managing medical careers (and the new contracts), they are very interested in that. There are committees and there are reports and there is always the board set up round about it, but you don't get the same emphasis on nursing." (N1P2C1 - SN)

This is considered to be led or exacerbated by the government and chief executives:

"How the board works with its members is very interesting... If something came out from the executive they are not interested in how it would be taken forward.... The main thing to a chief executive, is what can I land up in court over? .... That is what they focus their energy on. That is about financial and clinical governance and clinical governance denotes medics to them, so this is where the focus is." (N1P2C1 - SN)

This respondent quotes one board as having no Nurse Director and instead having to resort to an interim arrangement of one session per week for advice on professional nursing issues. This evoked feelings from nurses locally about the disparity between nursing and other professions where this would not have happened. Feelings were that nurses within this particular board had not been considered key players in decision making:

[10] N1P2C1-(SN)

"For almost two years there was no nurse director, so they lost the focus and impact of nursing... but it's not just about nursing, it's about the value they bring to the job, and the fact that they are the largest workforce. Medics have been very much running the agenda." (N1P2C1 - SN)

These comments presented are made by nurses. However other non-clinicians also spoke of similar issues.

The "effects of government reforms"

A number of issues in relation to recent reforms are given particular prominence: changes in the environment; an increase in the need for leadership and changes in relation to leadership and management behaviours.

"Changes in environment"

In describing the general feel of what it's currently like to work in the NHS many emphasised differences and changes over the last few years which have altered the climate and overall landscape:

"The terrain has got a bit rougher and the expectations have got a bit higher and the complexity has increased." (N6P1C1 - ET)

This was emphasised in certain cases more strongly and graphically by other executive colleagues:

"It's much tighter, much busier, much more frantic..... There are so many things to keep track of it would be easy to lose sight of some of them." (N7P1C1 – ET)

In describing how things felt previously it was said that: *"there was a bit more slack and expectations particularly around clinical practice were a bit lower." (N6P1C1 - ET)*

The perceived lack of 'freedom to manoeuvre' as referred to by a few is considered to be in direct contrast to that felt in previous years. Many referred to the 'umpteen initiatives' now that one had to keep track of and monitor, all of which needed to be planned and managed and also 'corrective action taken' if they were not considered to be going well. General criticism was also made in relation to the various inspection and audit processes:

"We are now surrounded by inspection regimes. You are inspected everyday by a different body, so within that framework leadership has to respond to these imperatives." (N2P1C1 - ET)

This point is substantiated in discussing the role of the executive team:

"The executive team is always in a context now of - we must be seen to be delivering for the minister; we must be seen to be performing to this standard; we must be seen to be doing this." (N2P1C1 - ET)

Although many make these points, respondents also say that in relation to leadership the same characteristics that would have been listed ten years ago are what are still looked for in a leader:

"The same things that made people successful ten years ago are probably the same things you look for in a leader." (N6P1C1 - ET)

However the point is made consistently and on numerous occasions that it is the environment in which leadership is exercised that has changed, particularly in

relation to what is expected, how decisions are made and justified. Many spoke of the need for people to be in the press and the need for accountability within the public domain. It is emphasised that whilst this is not directly about leadership it is leaders who are affected and whose roles and behaviours have had to change and develop in response. Put very succinctly by one: *"political influence and public expectation is influencing what we do."* [11] As seen here, being the boss is considered not to have changed but the surrounding environment has for two main reasons: the increased degree of politicisation and the degree of public scrutiny and transparency now required about how decisions are made:

"When I joined, the health service was essentially an inward looking organisation, where nobody really worried about the money and patients turned up and were treated but there wasn't any concept that they might have real rights. Now you've got the situation where the level of scrutiny by press, by TV, by MSPs, by MPs, by accounts committees, by auditors, by patients themselves who can surf the internet and gain information is greater than it's ever been. I personally welcome that but, it means that you have to exercise a much wider degree of skills in relation to how you exercise leadership within that complicated environment. Who decides how much money will be spent on one service as opposed to orthopaedic services? How much money will be spent on a new drug as opposed to an existing drug? Those judgements when I joined the health service over thirty years ago were implicit rather than explicit. If we withhold a drug from a patient now we are likely to see a legal challenge. At the very least we're likely to see a very articulate set of arguments rehearsed on patient cohorts that have had that drug elsewhere in the world and what the outcomes were. Therefore that means that the process whereby we have reached those decisions has to be able to withstand that level of scrutiny." (N3P1C2 - ET)

[11] N2P1C2-(ET)

There is a clear set of imperatives and parameters within which boards have to operate. There is a perception among some clinicians that: *"eighty per cent of strategy in any organisation is determined by other people."* [12] Within the NHS eighty per cent of the work is quoted by many as coming into the 'must do' category leaving only twenty per cent of any leaders' time open to possible change and innovation. One respondent in discussing how she spoke to her staff at appraisals said *"there is no such thing as a local strategy, or delivery plan - it's all national stuff"*, saying that in reality *"all we do is implement it"* and then in commenting on leadership; *"leadership has to adapt to this environment and context."* [13] That said many respondents also felt there was some capacity for local innovation. Importance was heavily placed by many on the way leaders implement and respond to directives, whether national or local:

"The tactical bit is about how you respond to it and how you position yourself. We have government policy; we have then got to do tactical processes and plans that actually respond to that.... If you work in Marks and Spencer's you might say the market is telling me this, just like the government is telling us this. There's very few people who can be like Richard Branson, who can actually say I'll go and do something completely different. Most of us are constrained by some element whether it's the power of the pound in the private sector, whether it's government policy in the public sector." (N6P1C2 - ET)

Despite the increase in centrally driven initiatives many felt reforms have continued to focus on the need to involve clinicians in the modernisation and redesign of the NHS. However organisations are still perceived as not encouraging and engaging clinicians in solutions to problems. There is a belief that people on the ground can change things but the culture and ethos needs to enable this to happen. In discussing the government's realisation of the need for good leadership to achieve

[12] N6P1C1-(ET)
[13] N2P1C1-(ET)

change, this respondent emphasises that encouraging general leadership has its limitations and underlines the need to involve clinicians:

"You need front line clinical leadership and engagement of clinical leaders if you are going to make reform stick and if you are going to genuinely improve services for the public." (N6P1C1 - ET)

In principal many agreed that this has encouraged more local and devolved leadership and added to this saying that leadership undoubtedly should be a distributed function and therefore we should be devolving roles and agendas. However they believe that despite this the dominant paradigm is command and control:

"It seems to me that within our operating context that the dominant paradigm despite the rhetoric to the contrary is command and control with a continued belief in hierarchy and that can militate against the devolutionary push we need to make and therefore on the learning agenda." (N8P1C1 - ET)

The pressure is on targets, audit, governance and performance management and this suggests to local systems that there is a preferred management style which is directional and transactional. In practice they felt this has resulted in allowing less professional autonomy and individual interpretation, more bureaucratic and prescribed contractual - type approaches, more accountability, but with a perceived loss of professional ethos and flexibility. Respondents highlight that, in contrast, at a local level they are trying to create an environment where command and control doesn't work. This respondent articulates in terms of leadership how this is perceived can be mixed:

"Some people see this as a great opportunity for leaders whilst others regret the loss, the independence and the ability and freedom to act that was there. Some of

it was a myth but some of it was real. You were reportable to your own board in a hospital, you had more manoeuvrability and a lot of current tensions concern what is devolved and what needs to come for approval." (N2P1C1 - ET)

When asked about comments in relation to perceptions of the increased focus on command and control this chief executive said that command and control has its place but felt that in something as individual as healthcare it should be questioned: *"it is very difficult to justify much space for command and control however it is equally difficult to justify much space for anarchy." (N6P1C1 - ET)* In discussing this and the role of the top team they related the difficulties involved in ensuring a healthy balance in the present climate*: "the interesting bit is how you create a supportive collegiate culture but at the same time recognise that for £600 million the public are expecting to see quite a lot of things happen." (N6P1C1 - ET)*

There was a perception among many that with reform has also come increased workloads particularly in relation to accountability and achieving specific targets and results. Emphasis was consistently given by interviewees to the focus on results and the delivery of targets and these were now accompanied by shorter and shorter timescales in which to achieve them. According to this respondent this meant that the *'whole feeling of the organisation is different'* and in discussing the role of the Scottish Government also emphasised how this had changed: *"they don't leave us and say, by March 'Will you do this please?' but they are checking up on us and want a report every month." (N7P1C1 - ET)*

It was emphasised therefore that leadership particularly at the top of the organisation needed to make sure that all *'of these things are kept on top of'* and leaders needed to ensure people were engaged and meeting targets. This experience demonstrates the agenda and approach set by the government and how this manifests itself at local level and how this then permeates through the organisation potentially affecting leadership and management approaches and

behaviours. In discussing this with chief executives, who have a key role in leading and translating this agenda for individual health boards, what becomes evident is the difficult balancing and juggling act that needs to take place between achieving targets and setting direction and developing services and change. A chief executive refers to this tension and says that no matter how developmental they may want the organisation to be, they have to achieve the targets and *"balance the books".* Whilst he says he would encourage the human resource, clinical governance and developmental side he is also saying: *"actually guys we need to tick those boxes";* that it is a juggling act and there is always a subliminal message which is: *"by the way balance your budget".* In discussing this in relation to leadership he comments that the interesting thing will be*: "whether I can sustain the style and survive as the money runs out. It's easy to be expansive and empowering when you've got lots of dosh."*

He then emphasises the difficulties in maintaining appropriate styles and behaviours and where it is now considered that previous transactional approaches would not be appropriate:

"I can think of other areas where I have been working with colleagues whose style was very different - most of them are no longer in the kind of leadership roles they were in." (N6P1C1 - ET)

This particular conversation also demonstrates the dichotomy and difficulties of nursing roles where expectations are great in terms of achieving professional, leadership and managerial agendas, but where the chief executive said at the end of the day he needs them to deliver specific things in a specific way. What was reiterated here was that the chief executive expects nurses to be consistent and therefore argues there is less room for autonomy. He says*: "the more you have to depend on people doing the same job in the same way the more you are forced into a uniform model."* They are needed to perform in a certain way saying that the

charge nurse: *"can't think well this is the six people I've got, let's think about the best way to deploy their talents"* [14], that someone has to be in charge, which brings models of hierarchy.

Tensions are also highlighted between the terms 'leader' and 'leadership' with some respondents indicating that the NHS *'struggles with the terms'* in that both are necessary but that they almost produce a contradiction in terms. In this executive member's words: *"the health service is based essentially on a team effort."* However they then qualify this and refer to the difficulty by saying:

"If you look at the public's expectations of healthcare around service quality, access, value for money and increasingly around personalisation, I don't think that can be delivered without leadership." (N3P1C2 - ET)

This issue is further confirmed by others who say that use of the word 'leader' when related to an individual can imply it relates to senior members of staff only and can detract from messages that leadership 'is everyone's business'.

"Increase in the need for leadership"

There was evidence that general discussions on leadership have increased within organisations and are now quite widespread. As a word 'leadership' is referred to frequently. Many however also feel that 'leadership' has been around for years: *"I've always been able to see a nurse who is a very good charge nurse - they were a leader."* [15] On further discussion what appeared more apparent were feelings that: *"leadership has always been there"*, but that use of *"the word leadership has increased."* [16.] The increased focus on leadership and the need to develop good leaders, particularly within nursing, over recent years was emphasised. However a few perceived this increase to be in direct response to government attempts to

[14] N6P1C1-(ET)
[15] N6P1C2-(ET)
[16] N5P2C1-(SN)

solve certain problems within the NHS rather than the need for innovation and development:

"There has been an increased focus on leadership as a way of solving problems the NHS has encountered." (N12P3C2 - SN)

Another felt that leadership hadn't really 'increased', or if it had, it had been *"accidental"* as opposed to being part of an explicit and concerted effort *"towards more defined NHS leadership."* [17]

Reforms therefore have not increased the focus on leadership but leadership has instead become a by-product of reforms. However it was evident that the drive by organisations to focus on leadership was definitely there with many interviewees referring to increased number of courses available and to the increased focus given nationally:

"Every policy driver that I know recommends that at all levels within the organisation there should be effective leadership." (N9P2C1 - LN)

In discussing the effects of these, many emphasised the change towards the delivery of results which demanded more focus on good strategic and operational leadership as opposed to management saying *"both of them have become probably more important to ensure things are happening."* [18]

Respondents however considered embedding leadership throughout the organisation and into day to day practice a completely different issue and one that is much more difficult to achieve: *"the reality of trying to develop leadership skills in your staff is a different rhetoric from the policy." (N9P2C1 - LN)*

[17] N10P3C2-(SN)
[18] N2P1C1-(ET)

Attention is considered to be on the development and role of leaders as individuals as opposed to leadership within the organisation or to the development of appropriate infrastructure to support either leaders or leadership in practice:

"I would say there is an element of tokenism, in that these people's focus is very much being on the leader and not the whole team, so the emphasis is on developing and nurturing people who have good leadership qualities which is all fine, but it has to sit within an organisation that supports that to happen." (N12P3C2 - LN)

In discussing any increase in leadership by individual organisations, or in the enablement and empowerment of people to use increased leadership skills, respondents were questioning:

"My anecdotal observations of that would be it has been extremely helpful for some people but they are left in isolation to get on with it... the burden is quite high for them because their expectations and their knowledge awareness is raised, but they don't necessarily have the support mechanisms to allow them to do the things they want to do." (N12P3C2 - LN)

What was reflected on was the questioning of organisations' commitment to staff and to embedding leadership throughout organisations which is thought patchy. Leadership positions and development are felt to be occupied by, and invested in, a few senior people. There has been an increase in the rhetoric that says leadership is important but this is not always visible in practice in any more obvious way than previously:

"I think there has been an increase in the use of the word 'leadership', I am not sure there has been an increase in the actual delivery or enablement in

empowering people to either improve their leadership skills or to highlight how good they are at leadership... I think it is like a buzz word and..., where is the commitment to that? And its commitment to all staff across the board because leadership is across the board, it could be the domestic, it could be the nursing auxiliary, it could be the rehab assistant. " (N15P3C1 - LN)

When it came to considering whether any increase in leadership had affected patient care many examples were given of positive benefits:

"No doubt about it. Particularly in terms of governance, quality of leadership has improved." (N2P1C1 - ET)

"I think the patient's clinical experience is probably better." (N6P1C1 - ET)

"We are seeing more people, more quickly and usually within targets - it's greatly improved the seamless survival from stroke, from unplanned surgery." (N7P1C1 - ET)

Nurses said improvement in patient care is more evident following the introduction of specialist leadership roles and considered it less apparent within general nursing. Too much emphasis is thought to have been placed on specialist roles to the detriment of others such as the senior charge nurse which they thought has been neglected until recently. Improvements they highlight include: increased access to services, achievement of targets and waiting times, improved audit and performance, decreased mortality rates in certain areas, increased skills, visible improvements in quality and improvements in the patient journey. Respondents describe improvements as complex, often not relating to direct patient care but to the redesign of services which involves subtle ways of working and influencing that doesn't involve seeing patients:

"You may say well you do five sessions a week in clinic so you make a difference to patient care. The five sessions where I don't see patients I probably make more of a difference. My non clinical job, one of the big strands is redesigning the re-perfusion service so that heart attack patients get treated much more quickly, and it's been a great success and that's made a big difference. Seeing patients in the clinic probably does that as well. I think what's often misunderstood is that it's the non clinical part of the care that impacts on the patient even more so." (N10P3C2 - SN)

They felt patient care had improved because: the quality of internal leadership had improved; there is a realisation of the failure of general management as a solution; there is more understanding of clinical and professional issues; and the need for clinical leadership and transformational approaches. Some notes of caution were made with regard to the focus on processes and targets:

"I'm not sure that by focusing on our processes we haven't lost sight of the patients personal experience." (N6P1C1 - ET)

"We are in danger in terms of patient care in forgetting what patient care is about because there is too much focus on targets - we have taken away some of the ability to care." (N6P1C1 - ET)

These examples and discussions raise three points and observations: firstly that despite an increase in use of the term 'leadership' many feel this is something espoused by the top team but in reality has not been embedded in practice or addressed in lower parts of the organisation. Secondly many interviewees thought leadership had not increased or changed significantly, yet the top team in contrast strongly articulated changes seen in practice. Thirdly, leadership and the effects of leadership are thought to have increased where specialist or new roles have been introduced as opposed to core services.

"Effects on leadership, management behaviours and roles"

Particular aspects of reform have affected how people carry out their role and have led to a change of focus. Changes in the environment have precipitated the need for different approaches and the need to practice more distributed and supportive styles of leadership. This has also been influenced by jobs becoming bigger:

"When you actually see the increase in the size of budgets and the focus on targets you need a different type of leadership." (N6P1C2 - ET)

"The rules, the policies, the structures, the culture are all different and that requires you to work in different ways, because there are different levers, different motivators, different rewards." (N7P1C2 - ET)

What respondents consider critical is how this is approached with the need for leaders to understand organisations and how they work in order to carry out their role effectively. This respondent refers to this as the requirement for *"self diagnosis" and the need for "really understanding the system and what is likely to work and what isn't."* [19] Evident in lots of conversations was the supposed shift in focus from management to leadership and from transactional to transformational behaviours and styles as indicated here:

"The policy agenda is about transformational change and for that you need transformational leadership. For years the NHS was just administered - it wasn't led - and everyone's job was just keeping it under control rather than to change it but reforms have blown that apart." (N7P1C2 - ET)

Despite feeling that leadership has not sufficiently been embedded within organisations it was acknowledged that reforms had allowed different roles and

[19] N7P1C2-(ET)

thinking to emerge which has created new opportunities, particularly evident in nursing:

"A lot of the typical pathways have gone so it has allowed people to emerge as leaders who perhaps aren't in the power positions necessarily - or the power shifts in different ways and people are given the opportunities to step up to the mark if they choose." (N7P1C2 - ET)

Many however said that this had happened usually only where specialist or new roles had been introduced such as those of nurse consultant. This respondent also raises the point that at a senior level, despite the command and control culture this had led to positive changes in behaviour:

"There has been an improvement in leadership behaviours adopted by senior people which empowers others because it actually takes a very special kind of person to really be empowered in a very controlling hierarchical organisation." (N7P1C2 - ET)

And this point is substantiated by another executive member: *"There were a range of behaviours which you could survive with ten years ago that you couldn't survive with now." (N6P1C1 - ET)*

In discussing roles many spoke of how things were now approached. Roles were about *"engaging with people for sustainable change"* and the 'bigger picture' in contrast to previous *"short sharp bursts of getting the task done."* [20] Respondents were *"constantly adapting and prioritising, making sure you tick the necessary boxes."* [21] Leadership styles need to be more facilitative rather than directive but focused on what needs to be achieved. The focus on targets and monitoring

[20] N1P2C1-(SN)
[21] N1P2C1-(SN)

dictates how you work with your teams and, as highlighted in relation to the chief executive role, many consider the need to balance direction and monitoring and giving people autonomy. A greater degree of delegation is considered necessary and the need to rely on others more to deliver. In practice this means ensuring appropriate monitoring. Some feel that despite the rhetoric this has led to an emphasis on the need for directive leadership styles and behaviours. Importance is placed on the development of tactics in order to respond appropriately. The need for these types of transactional leadership approaches however were considered important although the point is made that at present they are emphasised at the expense of more transformational leadership approaches and concentrating on developing the human side of the organisation. This interviewee illustrates the focus of the government on very mechanistic approaches emphasising a target, a project team, an action plan, a time line, and somebody accountable. Interest is considered to be in the achievement of outcomes rather than on how these outcomes are achieved or in the associated leadership behaviours required:

"They are very driven by the metrics. What they were interested in here are the targets. Here is your performance against the targets. What are you doing to ensure that? It was a very difficult discussion. We were talking about sustainability and what about organisational well-being, and what about the ability to recruit high calibre staff in the future? There are these two competing paradigms and it is very difficult to get them in balance, you have the bureaucratic approach and the transformational approach." (N8P1C1 - ET)

This then can lead to additional pressure within the senior team. These effects were felt to be less evident at grass roots level although many spoke of the effects on staff and how this manifested in practice:

"To staff on the ground your getting bombarded with directives like we need you to do this next, and we need you to do that. All these papers have been written and

these initiatives begun with all good intentions but there's been so many so quickly staff are confused." (N12P3C1 - LN)

This respondent indicates that how this plays out in practice also depends on where roles sit within the organisation which then dictates the focus and style:

"You've got general managers, you've got heads of nursing and there is a different focus and style within that. That then influences how you progress because you have to be led by that." (N12P3C1 - LN)

Some respondents said that their role had been created as a direct result of reforms and the desire to increase leadership. Confirming a point made earlier they spoke of shifts in the balance of power from existing hierarchies and of the positive effects this had had which would not have happened previously:

"Getting to sit at some of the top tables is absolutely paramount in terms of articulating and relating what the good nursing contributions are." (N5P2C2 - SN)

The "role and influence of the top team"

Respondents say that in practice leadership is influenced by the chief executive and their immediate top team and that their individual approach dictates the organisations values, direction of travel, style and behaviours. Importance is placed on them providing strategic direction, articulating what's right and wrong, being credible, ensuring implementation and monitoring. A clear distinction is made between developing strategy and service delivery. Respondents strongly emphasise that given the current environment and focus on targets the style of leadership and culture set by the chief executive is critical:

"Other people take their lead from it and that can be very pervasive and if the chair and chief executive set a positive culture it can be very powerful and permeate the

organisation – because people tend to take their lead from that and it sets a tone and an environment." (N8P1C1 - ET)

The importance of this was particularly marked when they spoke of targets and meeting financial obligations:

"The fact that he has a wider perspective and sees the transformational agenda as important and the creation of a positive culture are important; others then see that we see it as important." (N8P1C1 - ET)

One respondent commented on the positive 'open and honest' culture where she worked and said this showed others how to do things. In commenting about the management team she said *"it takes its line from the top"* and *"that is seen to be how others might follow."* [22] They make the comment that previously the culture had been 'management by fear' but now despite current demands placed on them this was now absent. This was attributed directly to the leadership style of the chief executive. This example and other related comments demonstrate the important role of chief executives and the need for them to delegate responsibility but ensure delivery of what's important. The styles and behaviours of the top team are described as having to reflect and adapt to these which affects how they manage staff:

"I think that it's different and that means you have to work differently with your teams because if that is the way you are going to be monitored then that's the way you have to monitor them." (N7P1C1 - ET)

This relationship and influence was discussed in relation to effects on their own leadership style, with respondents reporting the need to be aware of how the boss behaves and adapt your own style in relation to this, as articulated here:

[22] N2P1C1-(ET)

"I have been through so many re-organisations. I have lost count of so many different styles of structure as well as styles of manager, and people say how have you survived twenty-eight years? My answer is because I have been able to work out what style the person I am responsible to is working to and adapt myself to fit in." (N7P1C1 - ET)

They add: *"I have seen people going by the way side who have fallen, people who I have overtaken because they couldn't do that."*

Particular importance was placed on middle and first line manager level where the role of the top team is perceived to shape how leadership develops and how leaders are regarded. Many say that staff notice if leaders at the top say one thing and do another, or if direction is constantly changed. When asked about the top teams role and approach to risk taking, responses also confirmed that approaches were felt to be set by the top team:

"That's a characteristic of how the top team behaves. Some of those behaviours will encourage people to constantly report things while other ways will ensure people do take appropriate decisions." (N1P1C2 - ET)

Leadership is considered not to just be about how good or bad a leader is but about the culture and approach of the senior team:

"It's not just about people and what they bring to the job it depends on the culture within the executive management team." (N8P2C2 - LN)

Respondents spoke of the need for them to work together as a cohesive unit, displaying continuity in terms of direction, leadership behaviours and style. Emphasis should be on what is important and what's valued by the staff.

Respondents thought that these factors influenced whether staff wanted to work or do well for the organisation and if these leadership behaviours are not in place service delivery is disconnected from board objectives and strategy. They also place importance on the top management team (TMT) understanding what people within the organisation do, which if absent leads to perceptions of a detached top team, a culture of ineffective leadership, and a lack of innovation and change.

A senior nurse manager gives an example illustrating a number of these points, where a prior restructure had brought together two different organisations and two very different models of leadership. One model was based on general management and the other on clinical leadership. These two models were completely different in terms of ways of working, approaches, and cultures, one working in a very 'can do' way, and the other in a very 'can't do ' way. The latter was expected to report everything upwards within the organisation, had little accountability and the former was allowed freedom and accountability and was described by the respondent as being '*proactive but still formally led'*. She said that both models were considered a direct result of the leadership and values of the individual chief executives and top teams within those organisations.

The decision base however is still considered to be hierarchical although this was thought not necessarily negative. Interviewees are convinced that if the person at the top disagreed with something then it probably would not happen and the organisation's view would be to change the views of others rather than the leader:

"I think there will always be people at the top of the organisation who will have specific views on things - I'm not one hundred per cent convinced that if the views of the nurse on the street were at variance with those views there would probably be an effort made to change the views of the nurse on the street rather than the views of the leader." (N5P2C1 - SN)

"The top team definitely does command and control to a certain extent but they have got very tight objectives and yes there's the freedom to act but it's from the top down - but you wouldn't deviate from the top team's agenda." (N8P2C2 - LN)

This leader discusses the difficulty of trying to create the belief of staff that they have the freedom to act but also ensuring appropriate accountability:

"I try to instil in them they do have this freedom to act but that they are accountable for the decisions they make." (N8P2C2 - LN)

Interviewees perceive a gap between top team's perceptions and what happens on the ground, also highlighting differences in style and behaviours. At the top the style is fast thinking and dynamic needing to achieve change and improvement. On the ground the reality is that things take longer to implement which requires different skills and leadership behaviours. This difference creates a gap and the appearance of differing sections of the organisation having differing expectations voiced by this respondent:

"If you were to look at an inverted triangle there is a big picture but narrowed down to actual clinical delivery.... Leaders at the top need to be able to see that big picture ... They need to be able to.... identify priorities and communicate that. The more towards direct patient care the more focused that becomes and the more it is about delivering outcomes against the bigger picture. All of them are equally important leadership skills, but they are different. It is about actually being able to interpret what needs to be done, drive and co-ordinate a massive organisation in a consistent direction and being able to communicate that, being able to come up with a vision and know that is going to happen right down to patient care, in every team, in every ward. If you achieve that, you have been a very good strategic leader because you have brought people with you, you have empowered them,

they are up with the vision, they are committed to it. The skills at individual level are about how you would lead a team to actually deliver that." (N13P3C1 - LN)

Respondents also highlight differences in the way decisions are made and the way people relate to each other, considering that higher up the organisation people have similar levels of responsibility in contrast to a ward, or community team where there is one leader and a very hierarchical structure.

In discussing their roles as chief executives they place importance on three particular aspects which interestingly are aspects emphasised by others. Firstly was the importance of leading the team and ensuring it works effectively. This was regarded as: *"how you place your own stamp on the organisation", and "making the things that matter to me matter to other people"* [23]; secondly, the importance of attitude and leaders being "visible authentic and hopeful" and thirdly behaviours *"I expect my colleagues to behave to their colleagues the way I behave to them."* [24]

These comments reiterate the importance placed on setting out appropriate approaches, behaviours and environment given the current political climate. They emphasised the dangers of being cynical:

"If you can't be hopeful that what you're offering to people as a leader is a better day, a better vision, a better set of services, then how can you expect them to be inspired and follow?" (N3P1C2 - ET)

However despite all these factors ideally being in place, the point is made that this needs to be implemented throughout the organisation for it to be effective:

[23] N6P1C1-(ET)
[24] N3P1C2-(ET)

"I can exercise leadership in the job that I have and hopefully create an environment through which other people can exercise their leadership, an environment which is empowering and enabling. But at the end of the day if, at ward level if the charge nurse, the ward sister doesn't exercise that leadership, the whole enterprise is already flawed because I think I've got this grand strategic design, this commitment to patient care and the actual experience the patient is having in that little micro universe is rubbish." (N3P1C2 - ET)

Summary

Fully realising and achieving leadership potential in the NHS is clearly seen as a challenge by these respondents. This was articulated as particularly due to the effects of recent reforms, the complexity of structures and the number of differing professional groups. Over the last few years this has been exacerbated by an increased drive for transparency and levels of public and government scrutiny. This has led to a change in the environment in which leadership is exercised and in which leaders' have to operate. In order to respond environments have become much more reactive and focused, with an increased emphasis on targets, risk management, governance, safety and the need for change. In response there has been an increase in use of the word leadership and a change in leadership and leadership roles. Leaders are expected to be facilitory, empowering, enabling staff involvement and promoting clinical leadership at the same time achieving government objectives. Leaders' therefore have to constantly juggle and balance competing and conflicting priorities, targets, change and innovation. Critical factors identified despite these pressures are: the role of the top team and chief executive, how leaders respond and behave, and the need for leaders to understand organisations and how they work. The second data driven category presented following, discusses interviewees' views on leadership characteristics, styles and behaviours.

Category Two

Leadership characteristics styles and behaviours

This category relates to interviewees' perceptions of leadership characteristics, styles, and behaviours. The terms were often used interchangeably by respondents although differing meanings were ascribed to each. Definitions provided by the Oxford English Dictionary were used by the researcher as a guide:

***Characteristics**: "Essential qualities, traits, mannerisms, quirks or idiosyncrasies."*

***Style**: "The manner of writing, mode of expressing thought in language, or of expression, execution, action or bearing generally, the distinctive manner peculiar to an author or other."*

***Behaviour:** "Conduct, manners or deportment, treatment of others or mode of action."*

In describing characteristics respondents provided lists of desirable qualities which they referred to collectively as 'something you have'. Styles and behaviours were discussed in relation to how these characteristics were applied although with distinct differences. Styles were considered to be the tools or approaches used whereas behaviours were referred to as the 'how you do something' and 'something you display.'

"Leadership characteristics"

Respondents highlighted a number of desirable characteristics and expectations as being particularly important in terms of leadership and being a leader. Characteristics were listed in relation to three main areas: firstly those which were 'softer leadership skills'; secondly more 'personal characteristics'; thirdly those

which relate to 'leadership characteristics in practice' and the 'how' it takes place. Overlaps do exist with regard to different people's interpretations and links can be made between the three. Discussions with respondents demonstrated this interplay as emphasised here by two respondents who refer to the importance of a number of different attributes:

"Leader's have to have vision; they have to be grounded in reality; they have to have courage and they have to have ethics." (N4P1C1 - ET)

"The most important thing for me is integrity ..... Really good leaders actually spend more time diagnosing how to approach things and bring out whatever they think is going to work for that situation." (N7P1C2 - ET)

Characteristics such as courage, ethics and integrity relate to personal characteristics, whereas having 'vision grounded in reality' and diagnosing and interpreting relate to how leadership characteristics take shape in practice. The three categories and their respective characteristics are illustrated in Figure 4.1. on page 178. These categories are drawn directly from the data working across all interview transcripts and have been collated into a figure for ease of reference. The diagrammatic presentation seeks to depict the interplay and links between. Many respondents emphasise particular characteristics as being very important and for these interviewees the properties illustrated in the second Figure 4.2 on page 179 define leadership. Respondents were keen to point out that whilst these attributes are of critical importance, emphasis should be placed on how characteristics are shown in practice. They described the importance of what one called a *'horses for courses'* [25] view of leadership and a key characteristic of leaders was the ability to realise what was appropriate in given situations: *"people who are effective leaders are ones who have lots of different tools, lots of different approaches that they can apply in different settings." (N7P1C2 - ET)*

[25] N2P1C1-(ET)

Figure 4.1: Leadership characteristics

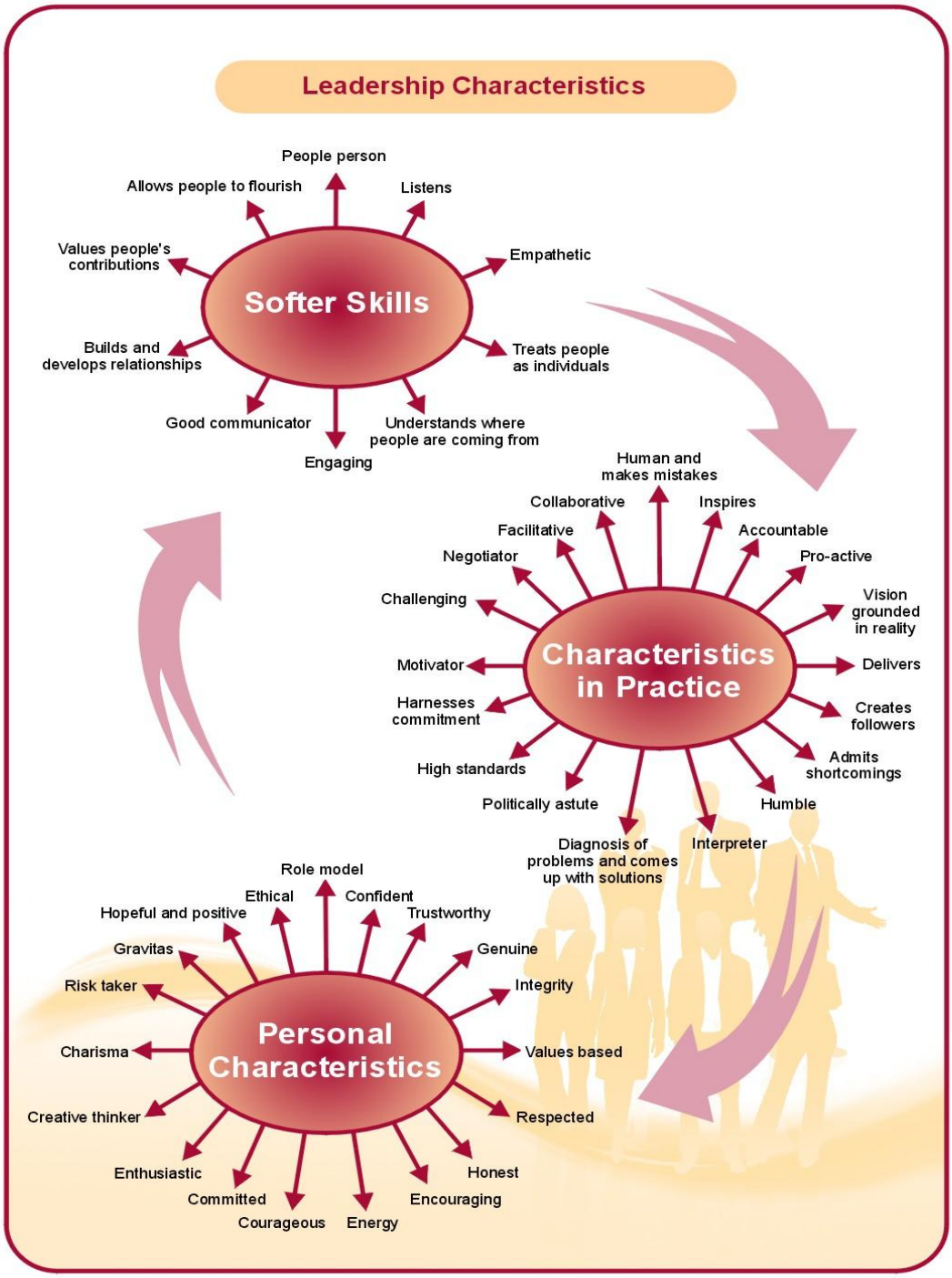
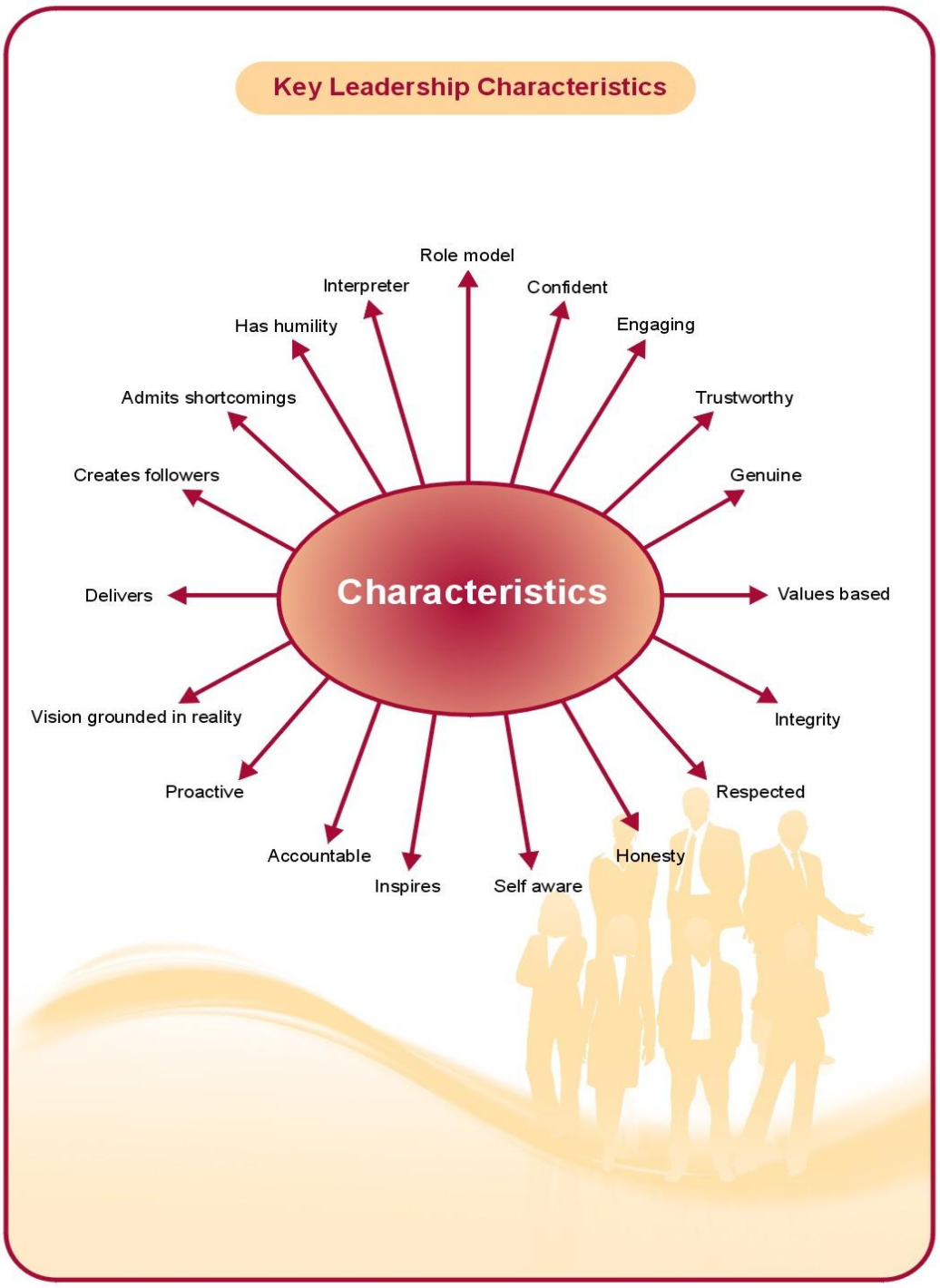


Figure 4.2: Key leadership characteristics



The need for transactional and transformational skills is underlined as is the need for personal gravitas and personal power rather than positional. In describing leaders this respondent sums it up as:

"1: Provide vision, 2: Motivate people to contribute to the vision, 3: Make it implementable, 4: Be part time cheer leader, part time someone who people follow." (N6P1C2 - ET)

Within the list of characteristics a number of respondents discussed some at length, the importance of having integrity, of being respected, credible and genuine, having humility and delivering: *"I think it is very important that leadership delivers - walking the talk" (N7P1C2 - ET). "Credible and confident and self assured but they are human, they make mistakes." (N13P3C1 -SPN)*

Respondents consider having clinical credibility in particular roles important. They think leaders should be able to demonstrate they have kept in touch and are aware of the real issues. Those who were at a senior leadership level consider the 'clinical' part of their role to be about ensuring they keep up to date as indicated here: *"one of the things I feel quite strongly about is that if you are going to be an effective leader you have to be real."*

"You asked me if there's a clinical component to my job... I have what I call clinical days where I turn myself over to the relevant heads of nursing.... So I go out and talk to patients, clients and staff and that physically recharges my batteries, it allows me to get in touch with what the issues are for the patients and staff." (N4P1C1 - ET)

Humility and admitting one's own shortcomings are thought important by many, illustrated here as important for two reasons: *"firstly because you need to be*

honest and show humility; second because humility develops a culture where people are unafraid to accept that they have more to learn." (N12P3C1 - LN)

Leaders were described as risk takers who *"don't stay in their safe zones"* [26] who *"have the ability to manipulate situations and people to obtain a certain outcome,"* [27] although it was emphasised that this does not affect their integrity and that their motives must be demonstrated to be right. In this interview this lead nurse discusses the need to achieve a certain outcome to improve patient care but was having to manipulate the situation and certain groups of staff in order to achieve that:

"They think I'm going to ask their permission. But it's not up to them, it's up to me. It's part of the, "I'll play the game", coming along to ask what they all think. You need to employ different tactics for different people, and doctors want me to come along in my little suit and say 'OK' and then they'll say 'yes OK'. It's half an hour out of my life to get what I want to get." (N11P3C2 - LN)

Despite all of these factors the majority of respondents feel the main need is to be 'good with people'. This ranges from the ability to work with people and to *"encourage and shape what happens"* [28] to the complex nature of leadership in practice:

"The key trick of a successful leader is that he/she is able to get people to do things that they wouldn't otherwise do, to want to do those things and to continue doing them after he or she or their attention has moved on." (N6P1C1 -ET)

[26] N15P3C1-(LN)
[27] N11P3C2-(LN)
[28] N9P1C1-(LN)

"Understanding where people are coming from and making them want to do things differently" respondents emphasise as a key skill: "there is a real skill knowing what to do, when to do it, and when not." (N7P1C2 - ET)

And conversely:

"Sometimes being a strong leader is actually not doing anything at all and not allowing yourself to be bounced into taking action when actually the status quo is important."

Linked to this is the importance of engagement and leaders need and ability to get people to respond and take people with them:

"They are able to describe what they want and take people with them and you can see that happening, the heads in the room, people in the committee, you can see they are agreeing and want to be part of it." (N4P2C2 - SN)

The critical point made is that leaders have not only to have the characteristics but have to have the skills to apply these in practice. This according to respondents is predominantly about the ability to engage, interpret, translate, and explain. This is emphasised here by these senior nurses, the first in explaining her role and the other in discussing how characteristics are applied:

"The role is one of interpretation, translating, telling and explaining reasons allied with the ability to try and put it in terms that actually mean something to people on the ground." (N9P2C2 - SN)

"The important point is not about you as a person but about how you 'flip the switch' in others, so that's about giving them the right tools the right preparation, the right kind of experience or opportunity. You coach them through that. Leaders

have the ability to have vision for the future, the ability to think strategically, make the linkages, understand what synergy is. It's not just a word in a book; synergy is a really live thing that people need to get their heads around, and leaders have that in abundance. They are able to do all that. And generally they have a creative spark as well." (N4P2C2 - SN)

The leader's role in *"protecting"* others from difficulties was frequently emphasised. In practice this is a constant balancing act *"protecting people and to try and allow people to flourish." (N8P2C2 - SN)*

"Leadership styles"

Respondents emphasised the difference between styles and behaviours although conversations indicate that in practice these factors are very closely related. Style is discussed in relation to three areas: firstly the need to have different styles; secondly the need to be able to adapt your style; thirdly what leadership styles are seen as important.

In order to achieve objectives and interact with a number of different audiences it is considered critical that leaders are able to adopt a number of different styles. They think leaders should almost have a 'toolbox' of differing leadership styles. Many consider that at a junior level one tended to adopt one's own style to leadership but at a more senior level where the environment becomes more complex and political, this was no longer sufficient, with leaders needing to be able to adapt style to different audiences and circumstances: *"if you have only one way of working you will be at a significant disadvantage and probably not able to get the best out of people." (N7P1C1 - ET)*

Respondents used examples of needing to play director and manager; one role is around motivating, encouraging and delegation and the other around vision, influence and change. This called for differing styles of leadership. One respondent

quoted the work of Ervin Goffman around presentation of self which needed to be different depending on the situation. This was described by other colleagues as needing to have *"multiple personalities"* [29] and *"more faces than a clock"* [30] and the need to adapt style and knowledge, to how one part of the organisation or an individual works. This is further illustrated here:

"If you always present yourself in the same way you'll never negotiate yourself through different situations. Leaders have a vision in mind and they think beforehand how this is best sold and presented, to achieve the outcome desired. This necessitates an understanding of the issues, and situation and the discipline and ability to achieve that." (N5P2C1 - SN)

Although respondents spoke of the need for leaders to have a 'toolbox' of different styles, in interviews they placed importance on how this was then put to use and implicitly seemed to refer to a 'kind of assessment or intuition' that takes place that guides them in what 'tools' to use in certain situations. This was not something discussed explicitly but was clearly a critical issue, with many making links and giving examples of where they did this in practice:

"You suss people out. You know what it's like working with new people: learning and sitting back and watching and observing what they do and working out how best to work with them." (N5P2C1 - SN)

This is again referred to here by this executive member: "*Part of the skill is being able to say now is the time to get a little bit firmer, or now is the time to back off." (N7P1C1 - ET)*

[29] N5P2C1-(SN)
[30] N5P2C2-(SN)

Despite reference to tools, this is also explicitly and implicitly referred to as being about you as a person and your ability to 'read' and 'get on with people'. Respondents say leaders need to be very *"people orientated"* [31], focusing on learning how to understand and deal with people. Leaders that do this are said to have a belief in staff and adopt styles that are based on knowing how to get the best out of people. In order to do that you have to realise that *"leadership is all about personal engagement"* [32]; and have no fear of tackling difficult issues. They feel that style changes with experience and is related to confidence in your own ability:

"*If you are comfortable in your own skin it reflects in your style and work; the less comfortable you are the more autocratic and less relaxed you will be. The more relaxed, confident and secure you are, the more enabling and facilitative you are as a leader." (N5P2C1 - SN)*

These types of leaders have a positive regard for staff, valuing their input and experience which can be seen in their style and behaviour. According to respondents they work on the belief that you are only as good as the people that work for you:

"One of the things I say to staff when I meet them is actually I'm only here to make you look good, I'm not here to make me look good. If I am doing things that are making your life more difficult then I'm doing the wrong thing." (N7P1C2 - ET)

The importance of having personal insight and being aware of strengths and weaknesses is emphasised strongly with certain people seeming to have considerable amounts of self drive and motivation. Respondents reported that leaders who were able to make a connection with them personally made a

[31] N5P2C1-(SN)
[32] N1P2C1-(SN)

difference. Of the styles valued (listed in full in Appendix 3) the following were regarded as being particularly important: approachable, engaging and having clear expectations.

Respondents frequently discuss the need for leaders to be engaging and say that there are certain people staff will listen to and others they will not and some people have the ability to get people easily to relate to them. It is considered these people have an ability and style which has conviction, credibility, and makes things real. They believe very strongly in something and gain respect. The significance of values is recognised by respondents in that they frequently mention them in the points they make. One informant notes that there is congruity between values, beliefs and style and when asked what these were stated:

"A lot is to do with your own values and beliefs and the way you then manage staff. Whether you are open and honest and approachable; also how you take and respond to the difficult decisions." (N11P2C1 - LN)

One respondent said that the most important factor in deciding whether to work for the organisations was*:"what was the sort of leadership style? What were the values of the chief executive in particular?"* [33]

Respondents also discuss style in relation to what they consider important in their role which involves emphasising the 'human elements', respecting others' ability, being a facilitator and *"allowing people to shine."* [34] Using words such as strengths, compassion, caring and professionalism, are important which are associated with listening and support as opposed to complaints and problems. The style and the emphasis of the leader should be on creating the appropriate environment and culture to allow these leadership styles to develop and flourish. This respondent

[33] N7P1C2-(ET)
[34] N1P2C1-(SN)

gives an example of two contrasting styles which illustrate the link with values and emphasises the point made about valuing and believing in staff:

"We do hand hygiene audits now, and on one of the wards, we got ninety per cent of what we should be aiming for, and another ward got ninety seven per cent, so I thought that's excellent. Well done! The director's reaction was 'well what happened to the other three per cent?' As if her saying that would motivate them, and they would say 'well I'll show her, and we'll get the other three per cent'. But that's not my style. If someone says to me well done, then I'll work harder for them. For me leadership is around that kind of nurturing and support, and getting someone to read out thank you letters, instead of complaint letters was a simple thing to do and I think had a much greater impact on staff rather than 'oh no here we go I'm hearing about a complaint again'. " (N10P2C1 - SN)

"Leadership behaviours"

Behaviours are considered to be the critical element of leadership relating to the application of characteristics and styles in practice and to the 'how' things are done. As this respondent says they are *"more action orientated"* and are about *"doing what you'll said, you'll do"* [35] and carrying through actions and promises. This respondent says that behaviours are what people see and *"are actually demonstrating"* and makes the point that often what somebody espouses is not necessarily what they do:

"What people think they are doing is not always what they are doing. People think they are being participative or they think they are doing that but in reality that is not how it's perceived." (N12P3C2 - SPN)

Another colleague in discussing definitions sees behaviours as 'veneers'. He feels that behaviours are similar to characteristics but *"behaviours are modified*

[35] N10P2C1-(SN)

depending on the audience" and require more of a veneer and polished approach and the ability to apply different veneers. He adds that people should be able to see these differences in approach:

"*If you ask say the chief executive or the DNS each would see a different side and spectrum of skills suited toward that particular audience." (N10P3C2 - SN)*

The difference in learning, knowing and reality are highlighted:

"We can know the theories but we can't necessarily put them into practice. There is something about working with someone you know will know all the theories about leadership and have been through a number of courses, but you don't see that in their day to day practice." (N12P3C2 - SPN)

This respondent then described a current conflict between two leaders, the crux of the issue being how that is managed and ensuring they have an effective working relationship. He tries to articulate the differences between theory and practice and to highlight the emphasis given in courses and discussions which often do not concentrate on pertinent and real issues:

"These situations test a lot of what we think we know about leading, about how to work with people. There is something very real and practical. Theory is often in generalisations and broad brush statements but on the ground it's about handling people and relationships. It often helps to discuss the nitty gritty and practical examples." (N12P3C2 - SPN)

Respondents regard particularly important behaviours as being open and honest, genuine, delivering and doing what you've said you'll do. A full list is provided in Appendix 4. The need to deliver as leaders was emphasised frequently: *"delivery is*

very important - it can be the simplest thing but being seen to do it is critical." (N10P2C1 - SN)

"One of the fundamental things about being a leader is about trust. If you say you are going to deliver something deliver it. If you can't deliver keep your mouth shut." (N1P2C1 - LN)

Respondents feel leadership behaviours are reflected in the culture and context of an area or organisation and are perceived as being evident in the surrounding environment. They refer to them as being palpable and almost visible. This is particularly reported to be evident in nursing - for example within the ward environment and role of the charge nurse. One respondent refers to the song by Shirley Bassey *"the minute she walked in the joint"* [36] with staff able to tell immediately where there is good leadership, and what's well managed and organised. Likewise the reverse is felt to be true.

Being consistent, giving clear messages, being respectful, firm, showing positive regard for patients, carers and staff, being confident in your own contribution and giving people the authority to 'mess up' are all considered important: *"one of the things you have to be able to do as an effective leader is make the omelette but not actually break too many eggs along the way." (N4P1C1 - ET)*

Leaders are expected to have their own views, be able to defend decisions, be seen to take risks, and be able to defend what they believe. One respondent uses the term 'bravery', in discussing the importance of confidence:

"No matter what kind of stage you are at the issues remain the same. But there is something about the bravery of taking it on and how people become more brave or confident to take something on without knowing what is going or not going to

[36] N4P2C2-(SN)

happen. The further people go up the organisation perhaps the braver they are? The issues are the same, the decisions are often similar types of things." (N12P3C2 - SPN)

As indicated when discussing leadership styles one of the overwhelming factors that comes through in interviews is the emphasis put on what could be labelled 'interpretation' and the need for leaders to recognise the differing aspects of their role and behave accordingly. This it was said could be passive, active or directive. This respondent says:

"How can I support, facilitate and encourage. Within the team I have responsibilities around governance, so there are elements of management. There is also the work across the whole CHP and is more directive than the work I am doing with others." (N13P3C1 - SPN)

This is confirmed by another two respondents:

"Sometimes you do have to compromise on how you do things, but not on values and beliefs. Leaders have to be able to recognise when they need to do this and what the most effective way of negotiating the territory is." (N5P2C2 - SN)

"Leadership is very much learning the system in order to be able to use it to great advantage." (N9P2C2 - SN)

Summary

Particular properties are identified by these respondents as depicting important leadership characteristics, styles and behaviours. Characteristics are related to individuals and personalities, and as such are difficult to learn. Leadership styles relate to tools and approaches and behaviours to how leaders demonstrate these in practice. Clear emphasis and importance is given to how these are applied in

practice. Leaders need to have the characteristics but also the skills to apply these. Critical factors are: firstly a list of important attributes - integrity, engagement, humility and success in delivering; secondly, the importance and ability to work effectively with people, and thirdly the ability to encompass both of these in practice by learning to cope with people, situations and contexts. Necessary skills also identified are: interpreting what's appropriate in given situations; the ability to 'read' and get on with people; self awareness and personal insight. Values are also considered to be related to management and leadership style. The third category presents respondents' views on leadership roles.

Category Three

Leadership roles

This category sets out interviewees' thoughts on leadership roles, how these take shape in practice and some of the challenges encountered. Data are presented under a number of sub headings: Types of leadership role; Leadership roles in practice; Clinical leadership, Expectations; Leadership challenges; Leadership in nursing.

"Types of leadership role"

Respondents describe roles as falling into three types, formal, informal, and those which are considered both. Formal roles are clearly defined, relate to managerial positions and are associated with transactional approaches and behaviours. Informal leadership roles in contrast are described in vaguer terms, often as new roles resulting from redesign of managerial positions, referred to as professional heads of service, advisory or professional roles. These are associated with driving change and transformational aspects and behaviours and relate more to clinical services. A number of different parts to roles are described which illustrate their complexity and multifaceted nature: a corporate role, a national and regional role; a professional / clinical role; an academic role; a political role and a partnership role.

Respondents said that different styles and behaviours were often required for each of these parts which could encompass both leadership and managerial elements. Leadership aspects are distinct from managerial aspects which they say are more structured and directive and centred on a framework of tasks, such as managing budgets and performance, achieving savings, delivering targets, people management, ensuring personal development of staff. These often present

challenges on governance and what was described as the 'business part' of the role. Leadership aspects are thought to have similarities but centre on transformational objectives: developing people and vision, service development, implementation, interagency and partnership working, negotiating, building relationships creating opportunities, and enabling people to take risks. This respondent sums this up saying: *"leadership is about lighting the fires while managing is about going over and putting them out."* [37]

"Leadership roles in practice"

Respondents discussed two main features: firstly *"what you do"* and secondly *"how you do it".*[38] Roles are viewed as working within board strategy, achieving government targets, ensuring staff go in the same direction, understanding priorities and what has to be delivered, and ensuring adequate resources to do it. In line with important leadership characteristics, styles and behaviours they considered other elements to be: motivating, inspiration, confidence building, transcribing policy and strategy, selling vision and direction, influencing and creating the appropriate culture and environment. Particularly important aspects also included; what was described as 'being a buffer', challenging practice; role modelling; setting standards and being supportive and enabling as highlighted here:

"Part of the skill is about being the buffer between the board and chief executive and the clinical teams on the ground." (N3P1C1 - ET)

"Challenging the status quo, pushing the boundaries, setting the strategic direction." (N4P1C1 - ET)

"Setting out expectations of behaviour and environment." (N6P1C1 - ET)

[37] N7P1C2-(ET)
[38] N1P1C2-(ET)

"*Setting very high standards, getting people to raise their game so they become dissatisfied with the status quo." (N10P2C1 - SN)*

"It's about enabling staff to give the care they want to give." (N10P2C1 - SN)

Many emphasised the active, practical and people-related aspects to roles such as *"recognising what makes people tick and what pushes the buttons."* [39] This respondent describes the impact of giving guidance and support to the people she leads and feels a measure of success is how invisible she is:

"So when you hear your words coming out of other peoples' mouths, you can think 'oh yeah' making an impact there." (N2P"C1 - SN)

This respondent summarises what he considers to be the two main aspects to his role:

"1: Reading and then creating the future for people. 2: Vision, direction of travel, the how we do that, ensuring mechanisms to measure, allowing people to get on with it, then coaching and supporting to achieve that." (N1P1C2 - ET)

At a senior level roles are described similarly although reflect more emphasis on values and setting the culture and tone of the organisation. This chief executive describes three parts to his role:

"Representing the organisation externally; leading the team and thirdly how you place your own stamp on the organisation. That is about values and instilling a sense of what matters to me within the organisation." (N3P1C2 - ET)

This executive nurse describes two main components, delivery and improving standards and performance:

[39] N9P2C1-(LN)

"Part one: A: Providing professional leadership. B: Translating policy and strategy, corporate and organisational objectives into meaningful things. C: Translating, interpreting and instilling the importance and relevance of priorities. Also to represent nursing, ensure a voice at the board and that you are seen as an effective contributor. Part two: Corporate role - contribute and own all decisions, good communication, giving people confidence and security, inspiring people." (N7P1C2 - ET)

In speaking about increased emphasis on leadership, respondents discussed the change in focus and approach of roles from practice development to now focusing on professional advisory and leadership aspects more centred on achieving changes in practice. The recognition that these roles need to be separate from managerial roles has brought a shift in emphasis and changes in approach which are more facilitative. They said the increased focus on leadership together with the development of new leadership roles has had a positive and visible impact on patient care and many positive quantitative and qualitative examples were given. It was emphasised this had not been achieved by heroic styles of leadership or by one person's ability or wisdom, but by empowering styles of leadership and by leader's realising skills already there:

"I would say I changed the culture and changed various ways of doing things but I would also argue that the team wanted to change... that the new chair and the board wanted to change, that the clinicians generally wanted to change and what you were doing was saying OK guys go ahead and change." (N6P1C1 - ET)

This chief executive emphasises the differences in approach and the aim for long term change as opposed to short term solutions:

"You can be the hero leader, leading your platoon over the top, but you're not trying to win a sprint, you're trying to ensure the population are seeing marathon winners everyday." (N6P1C1 - ET)

"Clinical leadership"

Respondents say there is a genuine realisation we need good leaders to achieve reform in the NHS and this needs to include different types of leadership, different lines of accountability and clinical as well as executive and managerial leadership. Members of the executive team spoke of the significance of the three clinical lead posts at board level; the Director of Public Health, Medical Director and the Director of Nursing, emphasising these roles were there *"ultimately making things better for the patient".*[40] The significance of these roles however was attributed to how they were valued by chief executives. This respondent illustrates this in talking about the importance her chief executive places on her clinical views and experience: *"there is a respect and acknowledgement of the role of nursing and clinical services which comes directly from the chief executive. "* She said: *"he values his clinical leads to play an important role and values their views, which creates the environment for a big lead clinically."* [41] She also feels this sends a message to the organisation regarding the value placed on clinical services and her particular role. Many respondents viewed their role as a clinical leader also emphasising the importance of clinical elements. In discussing her role as DNS this respondent says:

"It's not just a leader it's about clinical leadership which for me is about improving and enhancing the patient experience." (N4P1C1 - ET)

As illustrated the clinical element is considered to bring added value, particularly important in nursing, as it contributes to credibility and to how the role is perceived and accepted by staff:

"It comes down to lack of clout. I think clinical leadership is really important because I'm a manager I manage nursing. I manage a budget but ultimately I

[40] N4P1C1-(ET)
[41] N4P1C1-(ET)

need to be clinically credible. Money is really important and how we deliver our service is really important, but you need that clinical leadership, because you need to be looking at how it's going to impact on the patient and how it's going to impact on the staff. I could be a manager from British Telecom and they could manage the budget easily. It's a seven million pound nursing budget, it's easy to manage. But you need that leadership, presence and credibility to actually make it work." (N11P3C2 - LN)

These two specialist nurses differentiate leadership roles with a clinical background:

"I don't have any specialist knowledge or background in rheumatoid arthritis, chronic pain, MS, yet my job is working with the specialists in these areas to develop clinical care. I think it is the leadership aspect of that that allows that to happen. It's my clinical knowledge and clinical focus that gives me the credibility and allows me to pick up quite quickly what they are working on and where they are going. If I compare that to a colleague of mine who is in a role in a clinical field without any clinical background, the person is really struggling with actually understanding the clinical aspects of it and being able to see that makes sense on paper but is not going to work in practice. For me that is perhaps the difference between a leadership role without having to be a clinician." (N13P3C1 - SPN)

"The main difference is whether you are a clinical person or a non clinical person. If you are a clinical person then your focus is on in your clinical area but you are still leading. I would probably say background is important. I would say for myself I have a strong understanding of how wards and NHS situations work. They face common challenges that I hear repeatedly. So it helps me be realistic but also find ways to take things forward that addresses those challenges. If I didn't understand those challenges then I might not necessarily be able to find ways around them or take something forward." (N12P3C2 - SPN)

Other important factors in having clinical knowledge include: it keeps one grounded, one can relate more to what's happening, one is able to understand perspectives and importance more easily. Staff report it is important to be led by someone who understands the service. Clinical background was said to be particularly important for those in specialist roles where posts had been developed to lead a specific area. Importance was placed on having understanding of the issues; of what it's like to work in that environment and of being in touch with patient care and the staff who deliver it. Remaining clinically in touch was discussed as critical to effective leadership. Respondents felt leaders at the top of an organisation are considered good leaders by staff because they display certain characteristics and behaviours but also because they show they have not forgotten what's it is like to be on the shop floor and have a sound understanding of clinical issues. This respondent discusses this importance and what he refers to as retaining 'empathic understanding':

"I sometimes wonder if you are in management for a particular length of time whether you lose that distance from the clinical area, and wonder if your style might then change, with regards to an empathic understanding of what actually is happening within a clinical area and what that feels like for other people. It's a bit like being trained reading out of a book and then setting yourself up as a therapist." (N13P3C2 - SPN)

The point is made that although different people have different approaches in practice, they are differ because of their various experiences. In the NHS it is clinical experience which may shape certain approaches, behaviours and ways of doing things. These may differ from someone who has progressed from more managerial or administrative roots.

"Expectations"

Expectations of leaders were said to vary depending on their own personality and their differing relationships. Respondents pointed out that despite having one manager they were often answerable to other stakeholders:

"For example (1) a line manager wants me to cover her back and ensure that the workforce is safe and competent. (2) The clinical director wants me to challenge thoughts and practices and set out future vision. (3) For lead nurses and direct reports I provide a shoulder to cry on, a sponge to absorb their problems. (4) For the workforce I need to be able to justify what the lead nurses are doing, reassure them that's right and confirm what the bigger picture is." (N2P1C1 - ET)

Senior leaders are expected to provide direction on what's right and wrong, be credible, and try and ensure that people value your views and knowledge. At the same time they have to *"juggle what's important and inspire staff."* [42] This respondent summarises:

"For the chief executive I must provide expert advice, implement pieces of work and ensure nursing staff are professional and well equipped to deal with what's happening. Ward staff expect me to talk to them about the vision, to help them get there and to make them feel supported." (N10P2C1 - SN)

Respondents expressed a lack of clarity of roles saying that the detail of what is expected is not discussed and varied considerably from job descriptions:

"I've not had any clear 'this is what's expected of you in your leadership role'. The job description would say; develop service, promote role, almost based on your own interpretation versus what you can achieve, which in some ways can be very

[42] N10P2C1-(SN)

positive but comes back to the where you are and how you are motivated to do that." (N14P3C1 - LN)

What's expected is considered to be different from what happens in practice, which is more complex. The achievement of objectives is considered down to luck, or to individual interpretation or motivation. This was felt by some to be positive but many express concern that achievement is reliant on individuals as opposed to structured approaches. One respondent felt a good way was to describe roles as *"loose jobs."* [43] They also highlight that leadership behaviours and their achievement are given little if any attention. It is said that things are implicitly referred to but this is never directly stated. In interviews they thought a good example of this was the perceived importance of 'having a facilitative approach', and that this was a good example of something advocated but not monitored or assessed in practice:

"So I know what's expected as far as performance. As far as behaviour goes I think that's written within the lines somehow. There are hints in job specs and job descriptions but they are only hints and it's never quite articulated how not to behave or what kind of approach you should take." (N12P3C1 – LN)

A distinction was evident between organisational expectations and what leaders themselves thought important and wanted to achieve. Respondents said the need to make a difference, the need to improve services and standards were particularly important to them. Conversations reflected the need for them to make a mark, be good at what they were doing and to show their role had made a difference. Personal expectations were described in developmental and transformational terms and given as reasons for applying for posts. However in practice they spent time on financial management, governance and managing risk. Another key aspiration viewed as considerably important was the need to be a good role model but this

[43] N15P2C1-(LN)

was something not developed, monitored or assessed by organisations. Being a role model is important because: *"you take on board good practice and replicate it." (N11P2C1 - LN)*

"You learn as you go along taking and applying a little of what you recognise to be good in other peoples thinking." (N11P2C1 – LN)

"When someone encourages you and takes an interest in your personal development you see it as important and you then do it with others." (N9P2C1 - LN)

Role models are thought key in setting out expectations, behaviours and culture, in challenging and changing inappropriate behaviour and in creating strong leaders who court values and demonstrate them consistently in practice. They have characteristics that are visibly apparent making them stand out; they make a difference and influence people. They listen, guide not control, challenge, but also instil a degree of trust and confidence. They are calm under pressure, create a feeling of respect and admiration and are visibly seen to care about patients and staff. Other attributes listed are credibility and the ability to apply strategy in practice. Good leaders promote and publicise their work well, are incredibly inspiring and have an excellent ability to communicate. In selecting role models respondents said they admire and select people who have similar values, are on the same wavelength, and who they aspire to resemble. What was said to be as important is the learning that takes place from people who display the opposite characteristics:

"In relation to behaviour I can think of a few people who I admire as leaders and I do hear myself saying things they say. I don't mean to, it's just somebody I really admire. I also learn a lot from people I don't respect. That can be just as positive in shaping my behaviours because I know what I don't want to do. I can think back to student days and the mentors I had during my placement that I thought were

fabulous and the ones that I didn't. I can remember those who took time to make patients comfortable and those who ran patients down. These influenced what I became."

"Now I look to a manager who I think remains calm under pressure, is not reactive, is very proactive, has got fantastic skills in getting on with everybody no matter how they feel inside. Some people aren't like that; they personalise things. There are different people I would look to for improving things I don't think I do well myself." (N13P3C1 - SPN)

Having good role models alone is not considered enough however by this respondent to effect changes in behaviour and approaches although he is not sure what is required:

"I am working with a charge nurse on the ward. He is a fantastic role model, really interested in people and for this project he is gold dust because he is so person centred and his care is very flexible and focused on the individual. But there are those in his ward who are a million miles away from that and although he is role modelling, what is happening is not enough to change those people. In that ward situation role modelling is not enough. I would say when I work with my team it is really important that I behave in a particular way in the hope that they behave in a similar way but I wonder whether there are other things that perhaps influence more or if it's a combination." (N12P3C2 - SPN)

"Leadership challenges"

The biggest challenges were how to influence change, achieve quality improvements, and enable people to work differently. Many spoke of having roles which encompassed clinical, managerial and leadership elements, providing opportunities to influence decisions across a number of areas. This added complexity to roles could have the most positive effects on patient care although

had little to do with hands-on patient activity. Transformational leadership is not a priority valued by managers and many said it is not recognised as a legitimate part of leadership roles. Emphasis is placed on quantitative delivery functions and transactional leadership behaviours:

"It's the emotional, political intelligence aspects of leadership that have not been highly esteemed. It's been people who've got technical skills, people who are the kind that can deliver on service and financial targets." (N4P1C1 - ET)

Nurses highlighted that leadership roles are perceived as inferior to managerial roles with practice and professional development not valued as important:

"There is some perception that if you're not the one laying down the law then you are junior to any manager, but the qualifications you need for each post are probably equal in fact perhaps more I would argue. It's how people perceive your post and there's still that tendency within nursing to have a hierarchal approach to things and 'well if she's not my manager then she can't tell me what to do'." (N12P3C1 - LN)

Leaders are expected to achieve a number of different agendas simultaneously in shorter timescales. Respondents said this calls for both transformational and transactional leadership skills as opposed to managerial skills which were once acceptable:

"There is no doubt that the focus on nursing is up there with performance targets and there are targets for nursing that weren't there before. The floodgates those kind of things open up is immense and is about professional decision making, professional leadership, professional change: it is about how we work, accounting for it, and showing the benefit. It is about systems and processes and about patient care." (N4P2C2 - SN)

In discussing the change in emphasis of roles this respondent recites a conversation at a recent meeting which illustrated the shift in priority from ensuring good nursing care to minimising any adverse incidents or risk:

"The director of nursing in a trust when asked what her job said it was, 'to keep the chief executive out of jail by ensuring that nursing is good'. Now in essence there is nothing wrong in that because you do want that to happen, but you don't want that to be your prime aim. You want to lead a magnificent group of nurses to deliver to their best and the best to the patients in Scotland or anywhere." (N4P2C2 - SN)

Where the development of senior roles such as nurse consultant have taken place requiring both leadership and management a lack of synergy has been created with existing roles. This is due to differences in emphasis and behaviours which are said to be 'leadership' instead of 'management', change and redesign. Respondents said nursing was an example of where these dual functions often manifest in one role. This was particularly discussed in relation to middle management positions often occupied by nurses. It is considered a part of the organisation where leadership is absolutely crucial but where the least effort in developing leadership has been made and ironically where it would achieve the greatest rewards and outcomes. The role of middle manager / leader within the organisation is considered very challenging and a place where*:"somebody special is needed" defined also by this respondent as needing to be "someone with special qualities"* [44]. It is considered a frustrating role dependent on the top and bottom of the organisation working to objectives. Respondents say a disconnection exists between these two layers of the organisation not necessarily in thinking, but in meetings and communication. Meetings in the NHS tend to be hierarchically driven and are divided between the top (developing strategy) and the middle (delivery and implementation). It is middle managers who are charged with the responsibility to deliver key targets and

[44] N15P3C1-(LN)

achieve change to services within the organisation and therefore their roles are extremely important. A lack of realisation by the top team and the Government is highlighted particularly around issues and time needed to make change by middle managers at grass roots level:

"It takes longer to implement front line. That concept for someone at a higher level is difficult to understand. They expect it to happen very quickly and very rapidly and if you say 'no, that's going to take me six months' that's questioned. It's never said, but that question of 'it must be because my senior nurse can't be very good at winning people over, she's a bit slow, what is she doing?' Or 'is there something wrong with our staff?' 'We'll train them up a bit better' or 'we'll train them about change'." (N12P3C1 – LN)

The emphasis and expectations placed on middle managers to deliver targets, performance, quality, and service improvements, all within a strict budget has a negative impact on leadership, stifling creativity. Respondents say it is easy to become focused on what needs to be delivered and anyone or anything that may appear slightly different causes concern. Managers worry about upsetting the status quo and any attempts at leadership or new development are greeted with trepidation which is why respondents emphasise the importance of leadership development and input at this level:

"There is a gap. I myself have been in that situation, managing a budget, managing targets. You become very focused on that and anything that is slightly different is a bit scary because it might upset the applecart so you keep trying to do that. So there is something around their leadership that I think could be enhanced." (N12P3C2 - SN)

"You are in the middle and your frustration is quite high so you actually need to think of other ways of trying to manage so that the strategy becomes operational:

the operational becomes the strategy. That is where the softer or higher level skills of leadership come into play and that to me is where you need the development and the knowledge behind the actual leadership skills." (N15P3C1 - LN)

This issue reflects the tensions between the 'must do' and target-driven agenda and the need to develop services and make changes based on local need. Respondents discuss tensions between ensuring participation and ensuring outcomes with differences seen between the directional leadership and hierarchical structures necessary to achieve targets and the participative, empowering and transformational approaches needed to achieve change and improvement. Many said however that if responsibility for managerial aspects of the service such as the budget was lost you would lose the ability to be creative and ensure implementation. This senior nurse emphasises the conflict and feeling of pressure from above to achieve targets but also, in order to do what she considered important, she has to 'tick the boxes' first:

"Other people want me to make sure that everything happens the way they say it should happen and to blame me when it doesn't. I'm happy to do that. That's the way life is: tick the box, do the objectives, but what I want to happen is to see a well educated well supported group of nurses." (N9P2C2 - SN)

From discussions three competing components can be seen to exist in nursing: firstly, an agenda of delivery and targets; secondly the development of the service and thirdly the development of the professional aspects of the profession.

"Leadership roles in nursing"

Nurses are described as 'lynchpins' of the health service and as such leadership is considered particularly important. As the main profession in contact with patients, respondents said that if leadership in nursing was poor then the whole patient

experience potentially could be poor. It was therefore considered crucial to demonstrate the value of nursing and for senior clinicians to keep the focus of the board on patients. Leadership is seen as sitting with the Director of Nursing at board level working with chief nurses, clinical nurse managers or clinical nurse specialists. The creation of the DNS role at board level was emphasised as influencing the strength and importance of nursing's voice at a senior level. Highlighted is the need for recognition that leadership is a necessary skill to effect change, an important skill to enable nursing to be heard at 'top tables' and to articulate what nursing contributions should be. Leadership has become more visible, and nursing is considered more high profile with a visible change of focus, thought by respondents to be due to three main reasons: more opportunities regarding new and additional leadership roles; increased expectations to produce results and more accountability for activity. The increased emphasis on leadership development at shop floor level is discussed although some interviewees highlight political and strategic gaps in nurses' roles. One respondent emphasised that leadership traditionally has not been good at representing nursing and pushing the profession forward, noting that in Scotland the agenda is driven by the Chief Nursing Officer with a noticeable absence of nurse leaders in the news. In considering leadership roles respondents emphasised a number of particular issues and challenges which influence nursing in developing leadership and leadership roles: hierarchy and elitism; perceptions of leadership and management; perceptions of nursing as a 'passive profession'; perceived inequalities with other professions; and the lack of a supportive infrastructure.

"Perceptions of leadership and management"

Nurses were quoted as being parochial and hierarchical. They were not seen as a supportive profession but professionally jealous, where leadership and promotion were not supported or looked on favourably. Many examples of this were given such as this experience given by a senior nurse:

"A staff nurse phoned and asked if she could see me because she was interested in a piece of research. She had spoken to one of the medics who had said to give me a ring and I arranged to meet her. I had an e mail from her saying her colleague had reported her to her manager. She had got called up to see this manager who told her she wasn't to get in touch with me anymore. It wasn't appropriate for somebody at her level to try and speak to somebody at my level." (N5P2C1 - SN)

A perception of elitism is described with its own mindset and language which creates a distance from other professions referred to by one, as having a '*Marks and Spencer's'* [45] type approach, with nursing continuing to wrap itself up in a strange paradigm of its own.

As a profession nursing is thought not to value leadership or managerial roles and has a lack of realisation of the need to apply their wider skill base and influence at a senior level. When asked about what they thought contributed to this respondents gave a number of reasons including; historically nursing leadership has been poor and it has not been valued by the hierarchy, who have cut leadership posts and positions:

"If you've been at the bottom of the heap and you have power, you use it to keep the other people down. I also think we have had a tendency to promote people for all the wrong reasons and people get in a position that they've got power and authority and don't have the confidence and the knowledge. Leaders who are not comfortable with themselves provide unnecessary challenges for other people. They are not able to be challenged and don't seek feedback. Sadly we've got quite a few of these in nursing." (N4P1C1 - ET)

Respondents say nurses on the front line see the roles of their managers and leaders as separate hence the phrase 'them and us' and do not consider they

[45] N110P3C2-(SN)

connect to the top team within the organisation. In practice therefore unlike their medical colleagues they do not utilise these connections, regarding political aspects of their job as not particularly relevant. Many said that in some cases you are only considered a nurse by nurses, if you look after patients directly. Explanations for this were similar including: gender bias, a profession that has struggled to be valued and recognised and a history of promoting people for the wrong reasons. Respondents said that the types of people traditionally promoted into leadership positions within nursing were those interested in power and control. These were people who had the wrong approaches, skills and behaviours. They believed that such issues have not been addressed by the profession. Stress, working in adverse conditions, dealing constantly with issues such as death, angry relatives and a demanding public were also thought to have had an influence on nurses perceptions of leaders and managers. Gender is not an issue strongly emphasised but respondents do highlight the challenges of being a predominantly female workforce working in a large organisation with few women in senior positions.

It is considered that within nursing people have viewed leadership development as a way of promotion and moving on as opposed to a core skill. This has led to nursing valuing people who move on. If staff do not aspire to senior positions they are not valued or thought of as successful. Nursing therefore needs to invest in those who have leadership potential, but simultaneously also encourage people to stay where they are and do a better job as articulated here:

"If we actually focused on saying 'a job within that surgical area is absolutely critical and that's really good that you continue that' without feeling that unless they are aspiring to be a leader then they are not successful' and don't have a legitimate role. I would like us to get better at that."

This senior nurse then says what he thinks the approach should be:

"If we are saying to people 'what you are doing in this role is critical' and it's really good what you are doing. If you want to be a leader this is how you could do it, but equally, if you don't want to, we recognise you and the real value of what you are doing." (N5P2C2 - SN)

"Perceptions of nursing as a passive profession"

Nursing was described by respondents as a 'passive profession,' needing permission to act, with a reluctance to be autonomous, instead passing problems up the line. When asked why, reasons given were similar to those outlined previously such as: historic cultures within the profession, traditionally poor leadership, a lack of leadership training, inappropriate leadership styles, and a strong tradition of hierarchy. Nursing was quoted as being 'a solution-based profession' of 'doers,' rather than leaders and many thought this was why nursing has been passive as a profession. Respondents emphasised what they felt to be significant differences in nursing as a 24:7 profession in contrast to others who work on a more sessional basis. Respondents considered that this forces nurses into focusing on patient care, accepting what is happening and feeling unable to make changes to situations. Over many years this has had a cumulative effect on leadership and the profession.

Hierarchies are considered to have eroded a sense of leadership, responsibility and accountability, creating instead a culture of inaction. As said by one *'if I've not said it's to be done, then don't do it'* [46] and respondents discussed nurses' fear of being reprimanded for doing something traditionally done by a manager. Many said that nurses feel that leaders do not trust them to make the right judgement and '*do the right thing.'* In discussing this many were quick to point out inconsistent and unequal perceptions and expectations by senior managers. They said on one hand nurses are criticised for lack of initiative, but on the other: *"they can't even order a sandwich for a patient without someone senior signing the form. So that's the*

[46] N11P3C2-(SN)

baseline." They then add that in the same day conversely nurses could be asked to write an important business case for a new initiative:

"On the same day you could be asked at a senior level to write up and submit a business case because we need a nurse specialist. But because the case is not being submitted by general managers we are told 'well you'll have to write up a business case and submit that then we will decide whether that is supported'." (N10P3C2 - SN)

This respondent felt that this also demonstrates differences in what a nurse or nurse manager is asked to do in comparison to other managers or professionals whom they considered would be treated differently. Many other examples were given by respondents of what they saw as current inconsistencies in expectations and differences in rhetoric and reality. Here an example is given by a lead nurse when discussing recruitment:

"*They tell you to seize opportunities and I can't even authorise a band seven charge nurse. If one of my band seven charge nurses leaves I need God Almighty to sign off the manpower. So in one breath we are told to be innovators but it comes back to money and until we are in financial balance we don't take risks. I don't think we encourage or foster risk taking."*

She then discusses how she feels this affects nurses on the ward from what staff feedback:

"You are the charge nurse of a ward. You've got a two million pound budget, a supplies budget and you are responsible for twenty five patients and all these staff but you can't sign for sugar though because there's an embargo on signing for non stock items - so in one breath they are saying you are a manager but don't allow you to manage." (N11P3C2 - LN)

This point also demonstrates this lead nurse's frustration at not being able to influence and change this in practice despite being in a senior role. In nursing there is a perceived lack of leadership development and innovation, a lack of risk taking, responsibility and accountability, which is directly related to current NHS agendas such as risk management, health and safety, governance and complaints. Some however make the point that the nature of how these are applied in practice relates to leadership style, interpretation and application. In general however the introduction over recent years of more and more procedures to reduce risk has almost taken away the need to think and led to the creation of what is referred to as a 'dependency culture' which has hampered decision making and stifled development. They discussed the perceived intolerance of differences, slight variations or mistakes that may sometimes occur. They demonstrated further inconsistencies in expectations and reality saying that on one hand they are expected to be innovative but on the other are expected to adhere to rigid structures and procedures with the perceived fear of complaints or adverse events from of the top of the organisation.

They also highlight that traditionally nurses have worked to eliminate risk which has led to punitive environments and hierarchical and autocratic styles of management. The point is made that current agendas have shifted with much more emphasis on self care and empowerment. However, respondents still see risk and safety at the top of the list of organisational priorities, bringing with it directive and autocratic styles and behaviours.

These comments also demonstrate the effect of targets on nursing behaviours. Many respondents saw nurses, caught up in technical aspects appearing to lose sight of the human and patient elements. In trying to achieve targets they have lost sight of the bigger picture and what's most important as illustrated here:

"Yes there's a target and it's great if we can get it but it's not always right for everybody. The charge nurses were moaning a few weeks ago, that the patient gets their breakfast whipped away from them because they need to move, because they are going to breach a target in five minutes. So you cannot have your breakfast just now. That's just ridiculous." (N11P3C2 - LN)

"I was at a nurse consultant interview the other day and someone asked the question 'what policies do you not agree with?' One of them said well I agree in principal with the sixty two day wait for cancer. But if I told you at day fifty eight you had colorectal cancer, psychologically you might not be ready for treatment in three days time. So do I push you to meet the target? Or do I accept that you won't because for you it's right to wait more than three days? For the health minister it's not because she wants you treated." (N11P3C2 - LN)

This point demonstrates the importance of clinical leadership and the need for leaders and managers to have the confidence, understanding and ability to interpret what is right in certain situations despite not achieving targets. They should be prepared to stand their ground in explaining the reasons targets were not achieved. This senior nurse also illustrates where the organisation's focus has been and the pressure put on nurses to achieve targets. She then also illustrates the focus on technical aspects:

"The focus has been on 'we need to shorten length of stay to get these patients through' - because we need to reduce waiting times and waiting lists and we need to have discharges out before twelve weeks so we can get people in.." (N10P2C1 - SN)

"It feels as if nursing is becoming part of these processes rather than the processes being part of nursing. We need to get smarter at how these processes are done rather than seeing them as a separate entity and separate task. We need to get

smarter at doing things and enable nurses to have the confidence to take a step back and say 'wait a minute we've got patients amongst all this'." (N10P2C1 - SN)

"Inequalities with other professions"

Respondents perceive historic inequalities in how the nursing profession is regarded and supported within organisations in contrast to other professions such as medicine. Examples given by respondents are in relation to training, supervision, mentorship and reflective practice. Issues raised by many were competing values in clinical care delivery, ensuring appropriate training, and balancing expectations of their roles as leaders. Reasons given for this disparity included differences in training, hierarchy and professional culture:

"I think nurses can be culturally tuned in to being of a lower status. Certainly through my training I was conscious of where I stood which was, 'if you want to stand up and be counted that's fine', but you don't just do it naturally. So there's definitely an understanding of a hierarchy and I think that can be quite disabling for many nurses.

In my current and past jobs I have worked with people who really believed they had no voice other than saying something about coffee breaks or whatever on their ward. I believe we do have a voice and we can make changes but there are many practitioners who are working away, heads down getting on with it who wouldn't necessarily feel they could influence anything, and it wouldn't be their place to do that anyway. So I think there is a cultural thing about accepting what is happening and not having any wherewithal to make changes to that. That can affect the approach leaders might take." (N12P3C2 - SPN)

Some discuss feeling still subservient and lower down the hierarchy seeing roles negatively as picking up work from doctors. They emphasise this perceived

discrepancy has become more obvious as nurses have tried to develop services. This has created some tension:

"Whether I'm doing an endoscopy for a patient or whether I'm doing a nurse-led follow up clinic for a colorectal patient I suppose in a way you need the doctor's permission. So what is it that makes a doctor any different from me as a nurse? I've done my physical assessment course so I can examine somebody, I can give them their drugs, what is it? Apart from the 50K difference in your wages?" (N11P3C2 - LN)

Respondents feel that support, professional development and supervision, is regarded in other professions as important and essential to good practice but they say in nursing, despite policies dating back ten years it is the exception rather than the norm if this takes place regularly. They highlight that nursing has not been considered to have the same value as other professions with nurses always having had to drive and struggle to be better, demonstrated in constant attempts at gaining more and more qualifications, largely undertaken in their own time and without support. This with professions such as medicine which have inbuilt and recognised processes for support and development:

"With the flying start programme for newly qualified nurses one of the strands is working with and supporting them in their first year following registration. So far we have uncovered that it is an excellent programme as a product, but there are really pathetic processes in place to allow people to do it. Participants have to do it in their own time, they can't get access to a computer on the ward, and mentors who support them are not really aware of the programme. Some of the mentors are anxious and there are a lot of barriers that stop them supporting newly qualified nurses' doing them.

To me there is an incredible discrepancy between what support and learning time medical staff have as opposed to nurses. So here is a good example: we have an excellent resource, it can really help people, but we've got no capacity or process to allow people to participate in it. I had a conversation a couple of months ago with a registrar and she said 'I've got two afternoons a week to do exactly what I want to take forward'. I put the phone down and thought she's got two afternoons a week to take forward whatever she wants to take forward. That creates a massive discrepancy, a massive acceptance discrepancy, because that is not challenged. There is a huge inequality in those types of things and a power issue within a big hierarchal organisation that will increasingly frustrate nurses. It frustrates me because I see huge inequalities and people sense and feel that. Although the rhetoric might be positive in reality nurses see the discrepancy." (N12P3C2 - SPN)

"Lack of a supportive infrastructure"

Respondents see one of the positive effects of targets to be the increased number of leadership roles in nursing developed across the NHS. Differing structural changes have created opportunities for different roles and differing styles of leadership such as that of nurse consultant and nurse specialists. They highlight however that when roles are introduced organisations need to support their development. The examples of nurse consultant and modern matron are used frequently by them as examples of roles which have been introduced, tick all the right boxes in terms of leadership but are roles which are not supported in practice. Again comparisons are made with medicine:

"I know nurse consultants have been given a job description and tasks to achieve but they seem quite independent of the structures around them. There is something about being tied into the structures that are there but those structures having a common aim or agreed way forward rather than a nurse on her own trying to achieve lots of different things. If you look at a medical consultant, the team that surrounds that person is very different and there is often a team set up to

support that person which is not necessarily the case for a nurse consultant. A lot is left to their own wherewithal to make those connections and make those things happen. Boards need to look at how these people connect into systems that can actually be sustainable, and make a change rather than put a plaster over something. It is about knowing those systems, about knowing who the key players are and how to make that person connect in." (N12P3C2 - SN)

Summary

Respondents emphasise leadership roles in the NHS are complex and multifaceted. Formal, informal and hybrid roles are identified each requiring different styles and behaviours. Senior roles are thought to have more emphasis on setting the values, vision, culture and tone of the organisation. First line leadership roles are primarily concerned with motivating, supporting and characteristics associated with implementation. Middle management and hybrid roles are regarded as the most challenging, requiring a combination of senior and first line management characteristics, styles and behaviours and leadership and managerial components. The need for different types of leadership role is supported, particularly clinical leadership which is emphasised as particularly important. Roles can lack clarity and despite the emphasis and rhetoric placed on the importance of styles and behaviours these are not assessed or monitored in practice. Particular importance is placed on being a good role model and demonstrating values and behaviours. Leadership in nursing is regarded as particularly important but is challenging due to a number of historic issues. Of particular note is: the view of nursing as a passive and reactive profession; perceived inequalities with other disciplines; the lack of value placed on leadership and management roles within the profession; inconsistent expectations and behaviours within organisations and the effects of increased governance, targets and performance management. Category four presents respondents views on nurturing and developing leadership.

Category Four

Nurturing and developing leadership

This category presents interviewees' perceptions on: what supports and constrains leadership; how leadership is learnt and how leadership could be developed and improved.

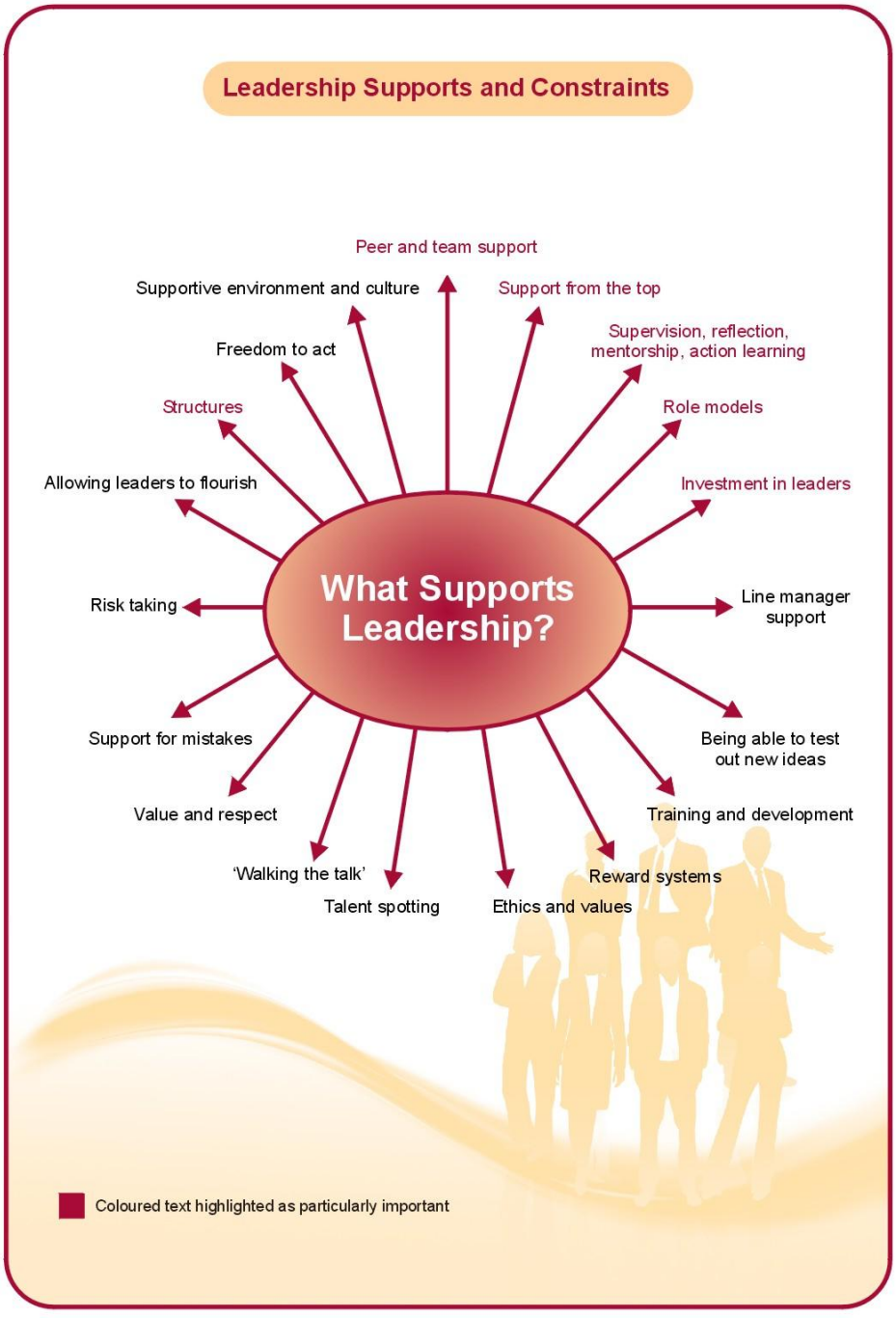
"Supports and constraints to leadership"

Respondents considered certain factors as particularly important in facilitating leadership. For ease of presentation, data are presented in Figure 4.3 on page 219. Six factors are strongly emphasised: team support, support from the top of the organisation; reflection; role models; investment in leaders and structures. Although identified separately respondents linked many of these factors in discussions, for example the role of the top team, peer support and support from their line manager. Team support and support from colleagues is considered particularly important in nurturing leadership and in creating good working arrangements: *"what supports me is feeling part of a team, feeling as if I've got a voice which is being heard." (N1P2C1 - SN)*

Many respondents again emphasised the important role of the executive team: *"it has to come from the top and the top is the chief executive; you have to have that freedom and support." (N4P1C1 - ET)*

As many respondents confirmed, this point also illustrates the balance that needs to be created by leaders, particularly senior leaders, between allowing freedom to lead and providing the right amount and type of support: *"what supports is the kind of direction, mind set and the example of people in senior positions and their attitude." (N4P1C1 - ET)*

Figure 4.3: What supports leadership?



This respondent identifies that if support from the top of the organisation was absent the landscape would look very different:

"Key top leadership roles would have to change; this would mean bypassing team members, not discussing things with certain members, which would lead to different closed leadership roles and a very different culture." (N3P1C1 - ET)

When asked about his views and the importance placed on this by respondents this chief executive agreed with colleagues and discussed the importance of trust:

"Running organisations relies on a high level of trust and as a leader you have to demonstrate your trust in your colleagues before they will demonstrate their trust in you." (N6P1C1 - ET)

This respondent agrees: *"the leader that trusts people to do the right thing is probably more likely to get a positive reaction." (N8P1C1 - ET)*

These points also identify the need and importance for leaders to be confident and self aware, making links with the characteristics, styles and behaviours already identified; particularly here the need for experience and the ability to exercise judgement and intuition in handling people and situations:

"You have to take the risk first and demonstrate your belief in them. If you wait until they have proved themselves to you and work on the assumption that until they do, they are incompetent you are lost." (N6P1C1 - ET)

This also introduces the importance of whether as a leader you are anticipating competence or incompetence and it is very important to trust and facilitate demonstration of competence: *"as a broad principal of leadership you need to believe in, invest in and trust them first and then that is repaid." (N6P1C1 - ET)*

Respondents make links between role models, investing in leaders and the principal of self awareness. In contrast to the previous section the importance placed on role models is in relation to values and culture which is considered the most important part of being a good role model which then *"reverberates around the organisation."* [47] Another key aspect is for them to challenge inappropriate behaviours. This director of nursing illustrates the links between the importance of role modelling and investing in leaders when talking about her personal experiences: *"I have been influenced by a number of people who showed me when I was relatively junior there are other ways of doing things ... senior people investing in me and my development had a really big impact." (N7P1C1 - ET)*

This is substantiated when a nurse talks about personal development and the importance of someone encouraging and looking out for you: *"one or two people did that for me in the early days and I feel I developed from that into who I am today." (N9P2C1 - LN)*

Respondents emphasise that although investment in leaders is important this is accomplished not by attending courses but by developing self awareness which should be gained by experience, reflective practice and by organisations creating the time and space for people to learn to lead. This should be about: *"reflecting on what your style is, what you are doing, how you go about it, how you adapt that to your own personality in the organisation to lead." (N1P1C2 - ET)*

This also needs to be coupled with identifying strengths and weaknesses and leadership style, which respondents feel is an extremely important skill in working with people and influencing them, but is a major constraint if leaders do not possess those skills and abilities. Points are made emphasising the importance of skills in emotional and political intelligence, defined here as: *"political intelligence is knowing who you need to influence in order to change something. Emotional*

[47] N4P1C1-(ET)

intelligence is knowing how to." [48] The point is also made by this respondent that sometimes leaders blame government strategy or policy and says the importance is on leaders' roles in how they respond: *"government policy and strategy is just a tool because you can manipulate that - it's about the political and emotional intelligence stuff again."*

The issue of structures is one which many discussed at length and is one which most respondents emphasise as extremely important in facilitating leadership: *"structures need to be there for support, advice and development." (N14P3C1 - SPN)*

Many think that by definition, in a hierarchical organisation a structure is required which is explicit but is not always regarded as particularly helpful although maybe a mark of NHS culture which does provide benefits. Given today's complex systems of working they feel there is a need to be very clear about responsibilities, boundaries, expectations and accountability with clear leadership roles and responsibilities. Many were quick to point out that this was not about being a manager or about being in control: *"it's not about being in charge but it's about clarifying limitations, expectations and accountability." (N12P3C1 - LN).*

Other factors that are emphasised as important in facilitating leadership include: environment, the ability to take risks and being allowed to be creative. Again in discussions many of these factors were linked. The importance of a positive environment and culture were considered paramount in supporting leadership but also one of the most constraining factors in leadership development. This conversation illustrates many of the points made by respondents:

"If you are in a very controlling environment and you don't trust people to get on and do it, and there is a mistake made, then rather than saying how do we learn

[48] N4P1C1-(ET)

from it, it's 'let's find somebody to blame and publicly flog them;'- that is constraining." (N8P1C1 - ET)

"We've often been identified in previous roles as people who were able to get things done, come up with new ways of working, new ideas, hard workers that are innovative that have gained respect locally from people clinically. We are then parachuted in and expected to sprinkle fairy dust over twenty year problems and then beaten up and stoned when we don't do it." (N5P2C2 - SN)

Respondents say that encouraging and facilitating leadership in today's environment is difficult because of the different drivers from ministers, politicians civil servants and the public, which do not necessarily facilitate what needs to happen in practice. They highlight that all would say that what matters is what works, but as said by this respondent you can only demonstrate that it works by having a supportive, enabling and participative organisation which is difficult to achieve in present circumstances:

"The public are interested in results and figures which are informed by the media; the minister is looking to see if you've ticked all the boxes, and whether you are likely to cause problems, and civil servants are looking at the same thing, but over a wider time span." (N6P1C1 - ET)

As well as emphasis put on positive leadership behaviours facilitating and supporting leadership, respondents said another way of supporting leadership was ensuring the organisation is seen to address and deal with bad behaviours. Many discuss this and strongly criticise the NHS for its perceived inability to address this in practice. Comparisons are made with the private sector where penalties are in place to address poor leadership performance. This and the consequences are

referred to here by this executive member: *"we see the fact that we shuffle mediocrity around."* [49]

The need to be creative and being allowed to be adventurous and take risks is frequently referred to. Respondents feel the ability to know they can be innovative without fear of repercussion is particularly important:

"Giving me the freedom to act in a safe environment and knowing that if it went pear shaped I wasn't going to be decapitated because of it." (N11P2C1 - SN)

"People who do have ideas and are coming up with solutions should be viewed positively because if you encourage people to do it and you knock them back every time then that's not going to encourage them to keep going. Any leadership ability that they had over a period of time will just - well they will think it's just not worth it." (N11P2C1 - LN)

"When you muck up - how it's treated and dealt with" [50] is important. A chief executive in discussing risk-taking says: *"part of the problem is that we are not so much risk averse as risk intolerant."* [51.] He emphasises that the NHS tends to worry about things going wrong and the more obvious downsides to change rather than the upsides saying *"certainly people are more vociferous about the downsides."* [52] When asked questions about constraints to leadership respondents highlighted opposite factors from those already discussed such as no reflection, action learning or development, a constant drive towards targets and focus on negative factors. Figure 4.4 illustrates the data respondents considered particularly noteworthy.

[49] N6P1C1-(ET)
[50] N2P1C2-(ET)
[51] N6P1C1-(ET)
[52] N6P1C1-(ET)

Figure 4.4: What constrains leadership?

In highlighting constraints this senior nurse ties together some of the points already made, not only illustrating the importance of trust but also the importance of leaders being able to balance different approaches and styles:

"Some people constrain leadership. It's very difficult for them because the reason that motivates them and the power base that goes with it is about power and control, and yet if you are saying it's about transformational styles that are enabling and facilitative that sometimes means that people may make mistakes but that's part of how you learn. If you like to tell people and performance-manage them and issue a script that people must adhere to then that's a problem, so I think that's what sometimes can make our jobs quite hard." (N5P2C2 - SN)

"Learning leadership"

Respondents believe leadership is learnt through experience and working through different situations: *"a lot of it is not formal, but informal networking and work that goes on in the system."* [53] Leaders need to learn how to deal with people through understanding different peoples' perspectives and situations. A number of factors are highlighted particularly such as learning from experience and reflective practice. Other factors respondents listed are presented in Appendix 5. A few of these are illustrated here:

"Leadership is learnt through role models and having a mentor. You can see what they do, or how they interact with people. A big part is communication. If you look at your communication skills with people, that's a good grounding because you're going to reflect and be open. There's role models and there's also learning from people who are not good role models and that's part of it as well." (N14P3C1 - LN)

"You learn from experience, by observation, a lot by practice and some formal training." (N7P1C1 - ET)

[53] N3P1C1-(ET)

Many said that all aspects of leadership cannot be taught but what is learnt is emotional and political intelligence. Communication and interpersonal skills can be refined but characteristics are considered part of someone's personality:

"Some of them you learn and some of them are intrinsic to people and some of them have to be built on." (N7P1C1 - ET)

Differences are highlighted between learning leadership and management which is considered to be more about practical learning. Respondents consider that in their first leadership post they tend to adapt behaviours around their personality which they refer to as their 'preferred style'. They emphasise that some people appear effortlessly to fit into leadership roles, whilst others have to make real efforts to learn the skills required. Being a leader is felt also to be down to individual drive and leaders have a way of succeeding and achieving more. Courses are believed not to be the answer in learning leadership and examples are provided where staff attend leadership courses, awareness is raised but practice does not change. They emphasise leadership is not about the role of one person or about one person attending a course but about the combined effort of a team which needs to involve addressing local environments:

"It's style and that thing that says: 'I know there is absolutely loads that I do know about, I know huge amounts about this and that, so it's OK not to know things'. But if you are in a blaming environment that's saying 'well if you do the slightest thing then I'll hit you' (which is what the environment is like), then you tend not to put your head above the parapet and you tend not to get opportunities." (N9P2C2 - SN)

It is considered impossible to expect to attain one consistent style of leadership, but respondents make comparisons with private companies which run specifically developed programmes for all employees with everyone expected to attend. They

thought this positive, something which could realistically be achieved and would benefit the organisation by providing improved styles and behaviours, outcomes and staff morale.

"Developing and improving leadership"

Discussions relate to four main areas: succession planning; recruitment and selection; developing leadership in practice and performance management.

Respondents often indicated that not enough emphasis is placed on assessing leadership skills and competencies or on creating the necessary infrastructure to support leadership. One of the main points respondents make is that no formal planning or thinking is done to prepare the next set of leaders and that a much higher profile needs to be given to succession planning and consideration of needs and objectives of the service. They feel this would create clarity of objectives and would assist staff in understanding aims and expectations of the organisation.

"What we're bad at is planning far enough ahead to develop the next cohort of people. There's no succession planning for the leaders in the organisation. Nobody is clear that if so and so was to leave or retire then it's successive, it's already identified, we don't do that. It's all hit and miss and who is available. When new directives come along like the greater emphasis on health and safety, clinical governance audit, risk management, complaints, waiting times, capacity planning, our answer has been we better create a post for somebody to manage this." (N7P1C1 - ET)

Organisations require the development of career paths to ensure benefits of those skills and roles. We need to ensure people have the right skills behind the title:

"We make the assumption that because you hold the post you have all that skill set behind you and that is not the case." (N1P2C1 - SN)

"The charge nurse that moves on hasn't necessarily been trained in the next step. They've been promoted because they've got an interest and ability that is coming to the surface." (N7P1C1 - ET)

Many believe there needs to be investment in people who have leadership potential to develop and use their skills and abilities. Currently they say a lot of rhetoric exists but little action. When leaders are identified they are not allowed to lead and space and opportunities are not created. The need to concentrate on improving selection and appointment of the right people into leadership posts was recognised by staff as a key area. Two issues were highlighted as problematic: firstly, the right people with the right skills are not selected; secondly when they are selected they are left unsupported. Both of these points are illustrated here:

"If you look at the senior charge nurse role we should be trying to look at the fit of the person into the wider team. We should take more time and select people not because of their technical skills but because of their leadership skills because that's what we want them to do. We want them to be change agents, to promote patients' experiences, to manage effective teams. We don't select people on those grounds." (N4P1C1 - ET)

"Then what we do is we put people into supervisory posts. The analogy I use is we give people the keys to a big powerful car and then say 'now learn to drive' and we abandon them." (N4P1C1 - ET)

Attention is also thought to be required in the selection of appropriate leadership styles and behaviours and transformational skills as opposed to technical competence. The suggestion is made that job descriptions should contain core elements of leadership and the associated behaviours required:

"We need to define what we want and separate it from the technical expertise. If you want them to work in a multidisciplinary team, if you want them to be a team leader, you go for transformational leadership skills because you can always get the technical expertise." (N4P1C1 - ET)

They think managers need to realise the importance of relationships and the need to focus on the human elements of leadership, which they consider the most important:

"I think as a health service we are quite good at being transactional but not so good at the transformational. The challenge is shifting the balance from the transactional towards the transformational and to get managers to see that the important thing in helping an individual's personal development is not completing the forms on time but the relationship." (N8P1C1 - ET)

"Quite often managers can be seduced into meeting the bureaucratic requirements and forget this is a tool or is a means towards an end, it isn't the end and the end is much more about the human dimensions." (N8P1C1 - ET).

As conversations with respondents progressed many gave examples linking a number of factors together including skills, characteristics, development and support, and what leadership roles feel like in practice. This respondent makes links here between the need for leadership and management and the different but associated styles, the importance of role models, the importance of self awareness and the importance of supervision and reflection in developing leadership:

"There are times when you have to manage and do leadership; that's the challenge with enabling and empowering rather that just this heavy handed or top down management. That is where the role modelling comes in. The key is knowing yourself, knowing your own strengths and weaknesses and knowing where you are.

The biggest tool we have had for a long time is reflection. The key thing for me around leadership as well is that clinical supervision never seems to have taken off truly in nursing." (N15P3C1 - LN)

Respondents highlight inequalities and differences in commitment to individuals' development related to seniority and role. They give examples of differences between the commitment given to senior leaders, charge nurses or first line managers to attend leadership courses. Many say the latter feel sidelined being expected to undertake various pieces of learning in their own time, which would not happen at a senior level. Limited capacity exists within staff groups to respond to or be involved in leading due to other priorities:

"A lot of events are in Edinburgh or Glasgow and nurses are busy now. They have to keep training. Sometimes strategic ideas and initiatives give way to everyday needs. If it's a choice between learning how to give IV antibiotics and going to that strategic event in Edinburgh, they'll go for the IV antibiotics everytime." (N12P3C1 - LN)

Respondents consider that nursing does not value leadership development or workplace learning and they say regulatory requirements are minimal and inadequately supervised. An example was given by one nurse who, because of her role had to register with two separate professional bodies. They said there was no comparison in what was expected by each in relation to evidence of learning. One had very strict criteria for practice, registration and educational development, reflective practice, supervision sessions, and research involvement. The other required minimal evidence to register and of ongoing development. The latter one was nursing.

Additional work is said to be necessary in ensuring the correct balance between academia, practice-based learning and clinical careers. Respondents say currently

too many barriers exist. Practice and theory need to be more integrated. There is a need to tackle current issues and tensions such as developing the role of leaders and what's expected, the problems of risk taking, responsibility and accountability.

The focus of organisations is considered to be on 'being a leader' versus developing leadership across the board. New roles are created and introduced into organisations as opposed to boards developing already established core services. Respondents say this has perpetuated feelings that leadership is seen as one senior person's responsibility, whereas in reality it is done by a team and needs to be embedded into everyone's role. Linking the words leadership and leadership roles is considered problematic also implying it relates to senior people as highlighted by this respondent:

"There is a danger that people mix up what they mean by leadership. The health service is based essentially on a team effort. If you look at what individual patients receive, they get that because a whole team of people of different disciplines, at different levels interact to produce hopefully a seamless, high quality product. There is a danger that if you introduce some heroic concept of leadership into this that it conflicts with the notion of what is essentially a team based undertaking. That said, if you look at the public's expectations of health care around service quality, around access, around value for money, and increasingly around personalisation, I don't think that can be delivered without leadership. The mistake people make is that they assume leadership is only me because I'm the leader at least in executive terms. Leadership is fundamental at all levels in the organisation." (N3P1C2 - ET)

Many consider the assessment of behaviours and performance crucial to effective leadership and to ensuring staff know what's expected of them. However they point out that leadership style is not assessed or monitored, with no formal feedback received on either style or behaviour. Respondents feel leaders should

attend mandatory leadership development to include a 360 degree appraisal and this would enhance the quality of leadership roles generally. Certain posts are highlighted as coming under particular scrutiny which is considered inappropriate. This respondent discusses the focus on his role saying that his is an example of a senior post created. He was appointed, hopefully, with the necessary skills and attributes to make a difference, and yet in practice his performance and behaviour is under scrutiny whilst others who he considers are not performing are not given the same attention:

"I did highlight that in my last performance appraisal it was completely ironic to focus on my performance, and having laid out all the performance appraisals for years I've never not once delivered on one thing, and maybe what they wanted to do was to cast their beam on some of the other people who were barely competent. I just think it is slightly ironic that you bring people in and say we want the very best, we want people who can do this and this and then they'll over performance manage them. That's just so typical of nursing. Then if there was just one thing I didn't deliver I would be beaten up for it." (N5P2C2 - SN)

Leaders and practice are not considered to be scrutinised in the same way as other staff. Many raise the question 'why not?' and make the point that this is not appropriate especially when behaviour can have such a detrimental effect on a range of people. Respondents say the focus of the government and boards is still on how we perform as a system with the general approach taken that if you're performing well then the leadership, styles, behaviours, and culture must also be good, which is not necessarily the case.

Summary

Certain factors are regarded by respondents as important in facilitating leadership particularly: team support; support from the top of the organisation; reflection; role models; investment in leadership and structures; environment and culture; the ability to take risks and be creative. These are also regarded as being some of the most constraining. Environments generally are not considered supportive or tolerant of 'learning on the job', instead being seen to be more concerned with blame and focusing on mistakes. The need for clear structures, boundaries, responsibilities, expectations and accountability is emphasised as is the difficulty of balancing leaders' need for support with ensuring appropriate freedom to act. In developing leadership, as highlighted in all other categories, emphasis is placed on the importance of leaders' attitudes and styles which then drive behaviours. Leadership behaviours and performance should be assessed and need to be appropriately concentrated on the right people. Investment in leaders is seen as very important but is achieved by developing self awareness, gained by experience and working through difficult situations. The need for leaders to be able to exercise judgement and intuition in handling people and situations is regarded as critical. Attention needs to be paid to: succession planning; in depth assessment of roles and skills required; improving the selection of leaders and the concentration on transformational aspects versus technical expertise. Leadership and the role of leaders are highlighted as being different; one being a team activity and one concentrated on an individual. Both need to be developed. The final category presents data in relation to leadership, organisational culture, environment and context.

Category Five

Leadership, organisational culture, environment and context

This category presents interviewees' views about organisational culture. This incorporates: definitions and characteristics; what makes a positive culture; what NHS culture looks and feels like and exploring the relationship between organisational culture and leadership. Although little difference was evident in respondents' discussions, the 'feel' and observed culture of the two health board areas was different. One area adopted and displayed a much more relaxed approach, apparent in both the tone and appearance on site visits and through the tone and conduct of interviews. The other appeared more upbeat, tense in relation to the government agenda and expectations of the organisation regarding performance which was also evident in interviews, conversations and attitudes.

"Definitions and Characteristics of organisational culture"

The following definitions were used as a guide by the researcher:

Culture: *"A set of key values, assumptions, understandings and norms that is shared by members of an organisation and taught to new members as correct" (Daft 2005).*

Context *: "Associated surroundings / setting" (Oxford English Dictionary)*

Environment: *"Surrounding, external conditions influencing development or growth of people" (Oxford English Dictionary)*

Respondents define organisational culture in very similar and largely congruent ways: a way people do things; the way people think and behave; kinds of behaviours; 'what's acceptable and what's not;' the style and content of organisations and as joint ways of thinking, acting and behaving. A fuller summary is provided in Appendix 6. Culture is described as a combination of the characteristics of people within the organisation and their styles of leadership, with these factors becoming 'a culture' when people are able to recognise them in practice and when a general view exists on how things are approached and done within the organisation. It is described as 'how it feels' being part of a particular organisation and includes non symbolic things such as sizes of office, what titles people are given, reward systems, mysteries, myths, rituals and traditions that have developed over the years and includes physical and emotional components. Respondents said these affect how people feel and are valued within organisations, how comfortable staff feel to say what they think and take risks:

"It's the atmosphere; it's something about the environment; it's something about people feeling a sense of worth, their identity. It's about people feeling valued." (N8P1C1 - ET)

This respondent says: *"what we've tried to say is that our culture will be defined by how we deal with one another."* When asked what that means in practice he adds: *"we have behavioural norms that expect us to treat one another decently, that we do what we said we'd do and a set of values." (N3P1C2 - ET)*

Many say this information is not written down but is knowledge gained through unspoken and learnt behaviour. Examples of this are given frequently by respondents. One particular example is that in terms of behaviour or ways of doing things they are not told when things have gone well, or that the approach taken was appropriate, but they are immediately made aware if behaviours or approaches are regarded as inappropriate or negative. They describe having to find out *"what*

the parameters are in which you are allowed to function at every level within that organisation" [54] and refer to this as almost 'a sort of sensitivity' which they have to pick up by osmosis:

"It's a kind of sensitivity. You pick up certain ways of approaching things, the ways meetings are organised, the way professional development is dealt with, the importance that's put on things, the way somebody deals with it if you have a personal problem."

This senior nurse discusses the appointment of her new manager which has brought various changes to the department and particularly to her role. In using this example she illustrates how things have changed, although this has never been made explicit: *"nobody would tell you that, it's not written down anywhere and there's no overt difference in what goes on but there is a sort of subtlety about it." (N5P2C1 - SN)*

They highlight that these rules and ways of doing things differ in every organisation and quite often in areas within them. They comment that some organisations have set out their values, principles, expectations, roles and accountability in documents and feel these are helpful with importance placed on communication of what's expected, what behaviours are rewarded and emphasised as important. Some say however that people make up the culture of an organisation and the organisation per se doesn't have a culture, so culture is what as individuals we allow or tolerate: "*culture is people - people come with a culture."* [55]

Respondents consider culture to be made up of two main features: behaviours and the environment, underpinned by values such as honesty, transparency and probity which form certain styles and behaviours. They identify a number of factors as

[54] N1P2C1-(SN)
[55] N1P2C1-(SN)

contributing to these such as; an organisation which supports people; one that positively reinforces good behaviour; how the organisation approaches risk and whether it is considered a learning organisation. The way organisations approach risk is particularly emphasised as being important and whether organisations are risk averse or whether they encourage and allow staff to take risks. In discussing its importance this respondent made links with needing to be a learning organisation:

"Is this an organisation which buries its mistakes because I don't want to hear about them or is it an organisation that can learn from its mistakes and uses them?" (N1P1C1 - ET)

Respondents refer to two differing views in the debate around risk saying that the top of the organisation considers it take risks and is quite innovative. On the front line however staff feel organisations are very risk adverse *"because you don't let people do things"* and because *"you've got to fill in forms before they can sneeze nowadays"*.[56] Respondents consider that being allowed to take risks makes an organisation a good place to work in or to lead, as opposed to the reverse which would be very unfulfilling:

"It's about the way in which people perceive the organisation on a day to day basis, how it impacts on their role and whether it enables them to do that role better or more effectively, or if it inhibits it. We've got systems and structures that we need to work because it's a massively complex organisation. It's whether they facilitate and enable you to do your job, or whether you actually feel so bogged down and disinhibited that it disempowers you." (N5P2C2 - SN)

[56] N2P1C1-(ET)

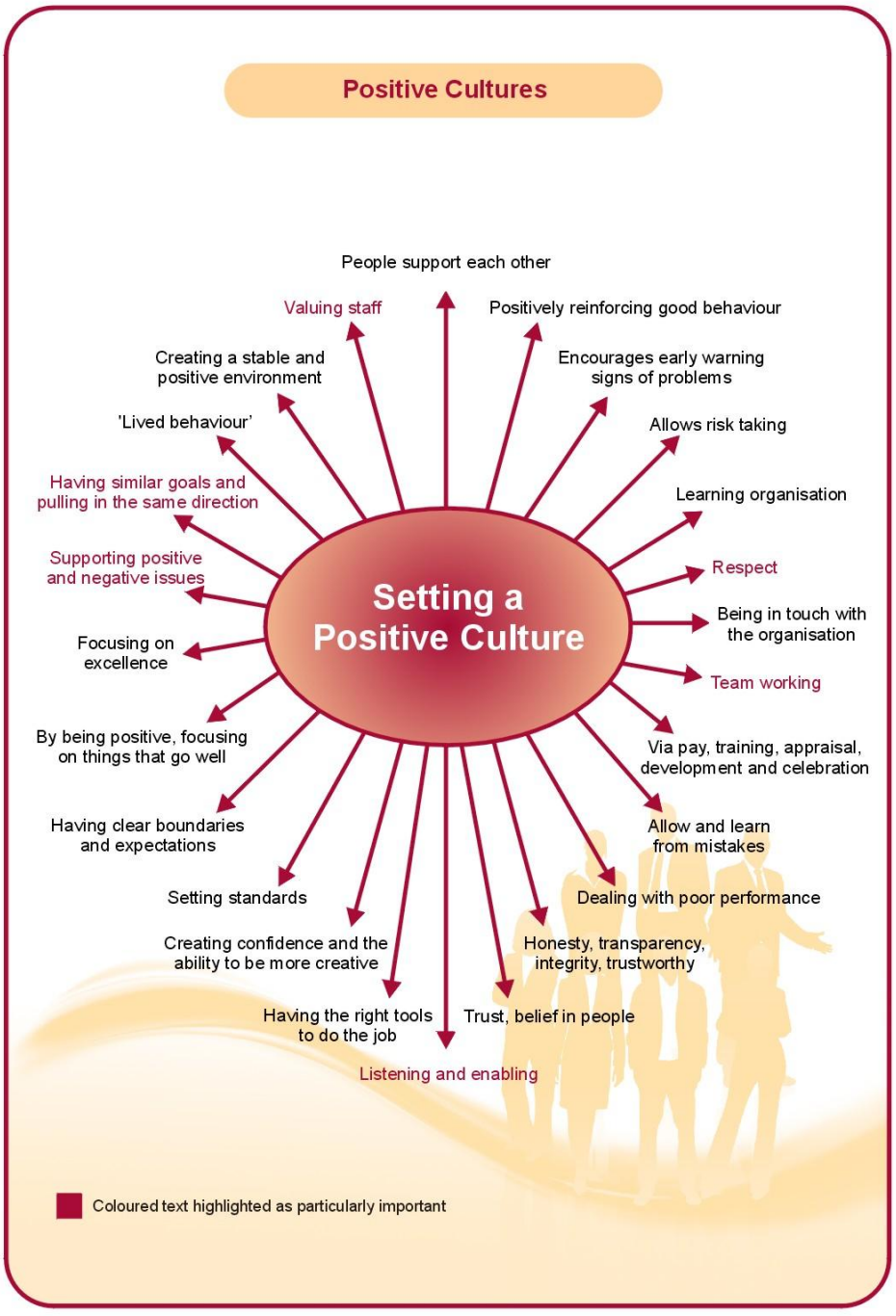
"Setting a positive culture"

Respondents highlight a number of factors as important in creating a positive culture and these data are presented in Figure 4.5 on page 240. The demonstration and implementation of these was considered very important and linked to positive results and outcomes. All of these factors are considered of equal importance although they emphasise a few factors particularly: valuing staff, listening and enabling; being in touch with the organisation and what goes on; having similar goals and pulling in the same direction, respect and working as a team; support with both positive and negative issues. Making messages, expectations and behaviours explicit were also highlighted as critical.

"NHS Culture"

Respondents consider health has its own culture set by beliefs and values and instilled through education. Comparisons are made with football in that organisational culture is how your team is set up to play and is extremely important in order to get the best out of the service. They make it clear that this is not the case in the NHS despite good intentions. Like football, it has its stars but often the team does not work effectively together lacking key components to make it effective. It needs a mixture of both superstars and workers. They speak of the many different types of culture and sub cultures using analogies such as a spider plant to try and explain the many component branches and cultures within professions, areas, and structures. The NHS is thought of not as one organisation, but a mass of different organisations, hierarchies and structures and of different leaders, clinical leaders and managers.

Figure 4.5: Setting a positive culture



One respondent refers to her role as being like a bee, working from area to area whose role it is to cross pollinate as she takes ideas from one part of the plant to the other. Many agree with this analogy saying this is exactly what leadership roles feel like in the NHS, hopping from one part of the organisation to another. Trying to create and manage any approach to a uniform culture in this sort of environment they consider particularly difficult.

Many believe it is very difficult to create an identifiable culture because of external influences such as the Scottish Government and numbers of different professional groups or 'tribes', which mean people do not have to conform to one set approach or way of doing things. They emphasise however the importance of organisations aspiring to have one culture which is *"open and supportive and one where you are allowed to try and get on with things"*.[57] This chief executive feels one of the main difficulties arises from people unintentionally receiving mixed messages from the board about what's important and valued. He refers firstly to the importance of *"getting all the ducks in a row"* and then gives an example of what staff may feel are inconsistent behaviours and values which affect the culture and environment:

"It's not about having signs on your door that say 'we are a caring organisation' that values our people and glossy annual reports. It's about getting all the ducks in a row and that takes time."

"They are being told they are valued, but halfway through the year when the budget is under pressure they cut the training budget - so how valued do you feel now?" (N3P1C2 - ET)

Many refer to any cultural change taking time which creates a huge amount of inertia in the NHS. This chief executive sees this is as weakness but also a strength

[57] N2P1C1-(ET)

saying that the NHS has survived and continued to deliver to virtually 100% of the population for 100% of the time:

"Organisational change of the kind expected in the NHS would have wrecked other organisations, or at least stopped them working for a while. Tom Farmer [58] *can say his objective wasn't 100% its 99%. If we had 99% I would be inundated with complaints from the 1%. So the NHS's reluctance to change, and lethargic pace has actually allowed us to continue surviving." (N6P1C1 - ET)*

The point is made that successful organisations really value their staff and the NHS often appears not to. One factor strongly emphasised is the importance of consistency between what's proposed and actual reality:

"We pretend we've got a culture but I don't think we have. You've got to follow up on things. You can have all the fine words and strategies but you've got to follow them through. Behaviours in the NHS are different from what's professed." (N1P2C1 - SN)

"Fundamentally culture is about us as an organisation, living the values we espouse." (N8P1C1 - ET)

Respondents give no consistent explanation for why this happens although many refer to the NHS still being a competitive market with CHP against CHP, professional group against professional group.

Two types of culture are described: firstly a board culture and *"then there's the rest of the NHS."* [59] Many discuss the impact of various restructures which take place at a senior level but where nurses on a ward would not notice any change.

[58] Tom Farmer is a Scottish entrepreneur who founded the Kwik Fit chain of garages in 1971
[59] N9P2C2-(SN)

Respondents feel that most practitioners on the ground would substantiate this saying that despite single-system or integrated-working many still refer to 'well that's not us, that's the board', with culture to them meaning their local environment or the environment or areas that 'touch' them. Despite this they say that staff would consider organisational culture plays an important part, affecting their perceptions of work and role:

"They would be very aware that organisational culture has an impact on whether they just get up in the morning and come in to do a job and go home, or whether they feel committed and believe in what they are doing." (N1P2C1 -SN).

Reference is made to the impact of the media and its effects on staff: *"we are always in the press getting complained about. That makes it very hard for people to get up and come to work." (N2P1C2 - ET)*

In discussing staff views of organisational culture this DNS agrees that staff perceive organisational culture as their ward or area - things that directly affect them:

"What will be important to them is the kind of relationships within the direct team and what they then see as the decisions made and handed down that directly affect them. So organisational culture is hugely important but they wouldn't necessarily describe it as that." (N7P1C2 - ET)

But illustrates the complex nature of culture and how this is linked with historic assumptions, myths and notions, using the example of her role:

"They will assign all sorts of behaviours to the rest of the organisation. They will have attributed behaviours to me just because of who I am without knowing who I

am at all. They'll have made all sorts of assumptions about what I care about, what I think important."

"Organisational culture and leadership"

Respondents emphasise that both leadership and culture are important and strongly related. In conversations they outline two distinct aspects of leadership: firstly, at an individual level, the effects of a leader on organisational culture and the effects on leaders of organisational culture. Secondly, at an organisational level the effects of leadership on organisational culture and the effects of organisational culture on leadership. Very clearly they say both of these aspects are interlinked with both acting in mutually reinforcing ways.

Leaders and organisational culture

Respondents feel the external environment directly affects the culture of health boards which is highlighted in relation to all five categories within this chapter and particularly seen in the effects of government targets. However they clearly emphasise that this can, but does not always, effect the behaviour of leaders. What they consider more important is the role of the top team, and particularly how the chief executive responds and behaves. In taking the example of targets respondents say the response by chief executives is critical and could be transactional or more transformational. Therefore despite the external environment it is this they feel that creates organisational culture, affecting both leaders and leadership. Another example of the influence of the top team's effects on organisational culture and leaders roles is given in discussing organisations' approach to risk and performance management. These respondents say that as leaders they need to exemplify the types of approaches chief executives are trying to develop, reinforcing the kinds of culture they are trying to create. As leaders they consider they have a key role in implementing these approaches and emphasise the point that leadership and culture act in mutually reinforcing ways.

This respondent says leaders need the skills to enable them to function effectively within the organisational environment:

"The two things are mutually enforcing. If leaders consider that they are the key influence on the types of culture we have, and if the culture is congruent with the types of leaders we have, they are balanced." (N2P1C1 - ET)

Many say that as leaders they can try to create their own culture and give some examples of where this has been achieved but they say very strongly that when there is not a supportive culture at the top of the organisation any change is very difficult to achieve and sustain: *"whether it was good, bad or indifferent, if it goes against the grain of how the board sets itself up, change would be very hard"* [60] and adds: *"it would be very difficult to have a mini culture in one part of the organisation that was trying to do things in a different way to everyone else."*

Leaders consider their roles directly affect organisational culture, but also discuss the influence of organisational culture on them. This lead nurse illustrates this in discussing two scenarios. The first example he gave was of the effects two differing leaders were having within a local hospital:

"I can walk round the patch and see where relationships must be strained. You can cut the atmosphere with a knife and the next area, it's a similar place but its fine."

The next example relates the difficulties in maintaining what he regards as a positive leadership style when the environment and organisational culture is influenced by other types of leadership:

[60] N7P1C1-(ET)

"People will phone and say 'I want a nurse to go to this meeting in Edinburgh on the 21st'. It is now the 19th – how can I get somebody for the 21st? I say 'sorry I cannot do that.' "

The reply is: *"Oh you will! and I say oh no I won't." (N9P2C1 - LN)*

He says this is not the style of leadership he advocates and neither is it the culture of his local CHP. The organisational response however is 'how dare he refuse' to do something and this illustrates the cultural conflicts that exist and what's regarded as acceptable behaviour in one part of the organisation is not in another. Other examples of the effects on leaders of unhelpful cultures are highlighted:

"I worked in other areas where its rule by fear and I hate that and I can't function under that. Some people are happy with that because the boundaries are very clear and they know they can't step over that line and if they do they get knocked back. If somebody bullies me I very quickly stop my development work because I feel threatened and my self confidence and my self esteem very quickly go under. If that happens to someone like me, then if you're a junior staff nurse and that's happening then phew! It's both criticism and fear. It's about "I expected you to do that, I gave you time and it didn't happen why not?"

She then illustrates a different and more positive approach:

"My boss may mean the same, but what he would say to you is 'you know we are kind of stuck. Is it finished? Have you managed?' It's the way you put it that makes you want to do it. If I had someone that came to me and said 'I'm really disappointed - that should have been ready for this meeting and by Monday morning next week I will have that on my desk!' I would be shaking in my shoes. That doesn't happen here but sadly it happens in other CHPs." (N12P3C1 - LN)

Some respondents question the importance of organisational culture to their role but qualify this by saying that this matters less to them now because they are experienced, confident and mature leaders. They know how to make the links and what needs to be done regardless of organisational culture because their job performance is not solely dependent on the surroundings of that one department. They say that for people on the shop floor it does matter particularly because they are directly under the influence of other peoples' views and behaviours and do not have the freedom to disagree:

"I couldn't care less about organisational culture because I recognise that it changes and blows hot and cold. I've got my own vision and if it was way off centre then I don't know if I'd have got where I am."

"People on the shop floor worry massively about culture and think it's far more sophisticated and influential than it really is. They worry about what the one or two people above them think and the power and the influence that they've got. People in practice put an awful lot of time and discussion round complete garbage and trivia wondering, second guessing and superimposing beliefs on people who they believe have an influence on them. Most leaders will just go on and do whatever despite the organisational culture, hopefully." (N5P2C2 - SN)

It is emphasised that all parts of organisations are different and importance is placed on leaders' skills in interpreting what is the correct behaviour and style in different circumstances:

"One of my key skills is being able to adapt to different situations. It's adaptability and the ability to read, and the ability to be willing to stand back at times." (N5P2C1 - SN)

"A leader is astute enough to suss out the culture and work with that culture to work with the situation." (N15P3C1 - LN)

Leaders strongly emphasise their effects on changing culture:

"What makes it change is to do with leadership. Essentially leadership can have an impact on the culture of an organisation." (N14P3C1 - SPN)

"To develop a forward thinking culture it has to be led." (N12P3C1 - LN)

What is emphasised as making a difference is the human and personal elements of leadership: *"it's all to do with how you make people feel, your behaviour and walking in and saying 'how are you today?" (N12P3C1 - LN)*

Leadership and organisational culture

Respondents emphasise that creating consistency is difficult because of the mass of different parts and groups in the NHS: *"it's too big and diffuse and there isn't a clear culture that permeates every part".* [61] The influence of leadership and influence of the top team is very strongly emphasised and regarded as critical to *"set the tone and style of what to do".*[62] This is supported here by this respondent:

"If people think there is a fractured, chaotic senior team, then the feeling from staff is that they are on the road to perdition, have no input and cannot make a difference." (N2P1C1 - ET)

When this occurs this senior nurse discusses the difficulties*:"There is so much disorganisation that it stops you from becoming a good manager or leader because of the utter chaos we find ourselves in." (N9P2C1 - LN)*

[61] N5P2C1-(SN)
[62] N2P1C1-(ET)

The role of the top team and particularly the role of chief executive is considered to dictate what's considered important and influence organisational culture in a number of ways. The importance of junior leaders knowing who the top team are and how they function is summed up by this respondent:

"Without knowing who the leaders are, how they tick, or the culture of the top team it would make leading and delivering impossible..... You need to know the agenda, the style, the bullets to fire and the culture. So knowing the culture is really important to doing the leadership role." (N10P3C2 - SN)

Importance is placed on the chief executive setting out what's important. This respondent discusses the possible influence of targets in her area saying *"it's amazing the amount of people in leadership roles I work with and they never mention a patient"* [63] emphasising that her chief executive ensures the focus remains on clinical services and improving patients' experiences. His role is considered crucial in setting culture and direction:

"It is the key leadership role for the board and chief executive to set the cultural tone of the organisation because if it doesn't come from there it won't happen anywhere else." (N1P1C1 - ET)

In discussing achieving cultural change many speak of the difficulties and longevity involved, however it is emphasised that despite this a change in chief executive can have a dramatic and instant impact on culture and this respondent discusses the effects in a change of chief executive where this happened:

"Now people are petrified for their jobs, non performers especially. It's changed overnight to be a very macho in your face organisational culture." (N10P3C2 - SN)

[63] N1P2C1-(SN)

The culture of individual CHPs is also clearly attributed to leadership from individual general managers. They feel difficulties occur when individual CHPs are brought together to work as one organisation as *"we are trying to bring together different leadership styles, different cultures, different everything."* [64] Whether this is achieved or not they feel *"depends on how strong the overarching leadership is"* and *"who has got the responsibility to set the culture."*

Summary

Organisational culture is defined in similar ways by respondents and is considered a combination of the characteristics of the people in the organisation and their styles of leadership. It consists of behaviours and environments underpinned by values which form certain styles and behaviours. A number of particular factors are identified as contributing to organisational culture and a clear set of factors are thought to facilitate, constrain and/or create a positive culture. These include: valuing staff, listening and enabling; being in touch with the organisation and what goes on; having similar goals; respect and working as a team; and support with positive and negative issues. Of particular note is how the organisation approaches risk and whether it is regarded as a learning organisation. Information about organisational culture is not written down but is gained through unspoken and learnt behaviour. Having an identifiable organisational culture with clear values, principles and expectations is regarded as positive but particularly challenging to achieve due to the complexity of structures, professional groups and size of organisations. A lack of synergy between teams is identified which creates different cultures and militates against the desire for one cohesive culture. Key factors identified as unhelpful are: firstly, inconsistent messages and behaviours; and secondly differences in espoused behaviours and reality. Direct links are felt to exist between organisational culture and leadership with culture perceived as particularly important to leaders in exercising their role. Both leadership and culture are seen as being interconnected with one influencing the other. Two

[64] N13P3C1-(SPN)

distinct aspects of leadership and organisational culture are identified: firstly, an individual aspect relating to the effects of leaders on organisational culture and of organisational culture on leaders' roles and behaviours; secondly at an organisational level, organisational culture's effects on leadership. The role of the chief executive and top team are considered critical and the main influence on the development of organisational culture and leadership and in determining the relationship between the two.

Concluding remarks

The findings presented in this chapter were issues highlighted across both cases and groups of participants within all three phases of the study and therefore related to all participants at all levels in the organisation. However within each category specific points were emphasised by certain groups and / or phases. This highlighted that some issues play out differently according to role and levels within the organisation. Table 4.1 below and on pages 264 - 266-highlights these key issues, the different levels and groups and the category the issues relate to.

Table: 4.1 key issues

Phase / group	***Key finding***	***Category***
Phase one: Executive team	The increased need for transparency, levels of government and public scrutiny has led to a change in the environment in which leadership is exercised.	One:
Phases two and three: Senior nurses	Reforms have emphasised the business side of healthcare rather than focusing on patients needs and service development.	One
All phases and groups	Environments have become more reactive and focused which have affected behaviours and roles	One
	There has been increased use of the word	

Phase one: Executive team	leadership and an increase in leadership roles.	One
Phases two and three: Senior nurses	The only real increase in leadership and leadership roles has been in specialist areas.	One
Phases two and three: Senior nurses	The role of the chief executive, TMT and how they behave is critical in relation to how focused or reactive the environment is in practice.	One
All phases and groups	Key leadership characteristics associated with clinical leadership and valued by clinicians are identified as; integrity, honesty, humility, engaging and getting on with people. These are considered to be related to peoples personalities and therefore are difficult to learn	Two
All phases and groups	Styles are key as these relate to how characteristics are demonstrated in practice.. leaders need the skills to apply these and the ability to adapt these to situations and contexts.	Two
All phases and groups	Values are paramount and relate to leadership and management style	Two
Phases two and three: Senior nurses	Different behaviours and theories of leadership apply at different levels within the organisation	Two
Phases two and	Having positive role models is particularly important.	Two

three: Senior nurses		
Phases two and three: Senior nurses	Leadership roles in nursing are complex and multifaceted, all requiring different styles and behaviours.	Three
Phases two and three: Senior nurses	Clinical leadership roles bring particular challenges and conflicts associated with differences in values, expectations and objectives.	Three
All phases and groups	Senior roles are more associated with values, vision and setting the culture and tone of the organisation.	Three
Phases two and three: Senior nurses	First line leadership roles are more concerned with motivating, supporting and characteristics associated with implementation. Middle managers and leaders require both sets of skills and qualities.	Three
Phases two and three: Senior nurses	Leadership roles should be clarified and assessed.	Three
All phases and groups	Targets have had a detrimental effect on roles and behaviours particularly in nursing.	Three
Phases two and three: Senior nurses	Factors that support leadership are work experience, positive role models, positive environment and culture and TMT support.	Four
Phases two and three: Senior nurses	Current environments are seen as focusing on blame and mistakes.	Four

Phases two and three: Senior nurses	Poor leadership and performance should be assessed and addressed.	Four
Phases two and three: Senior nurses	The selection of leaders needs to improve and needs to concentrate on transformational aspects as opposed to technical expertise.	Four
Phases two and three: Senior nurses	Currently leadership development develops individuals as opposed to developing individuals to work in organisations.	Four
Phases two and three: Senior nurses	The role of the chief executive and TMT are critical and are the main influence on the development of organisational culture and leadership and in determining the relationship between the two.	Five
All phases and groups	A positive culture and context are created by valuing staff, listening, enabling, ensuring people feel involved in the organisation, allowing risk taking and by creating a learning organisation. Inconsistent messages and behaviours and differences in espoused behaviours and reality create the opposite.	Five

Categories:

1. *Exploring leadership in the NHS*

2. *Leadership characteristics, styles and behaviours*

3. *Leadership roles*

4. *Nurturing and developing leadership*

5. *Leadership, organisational culture, environment and context*

The final chapter discusses the implications of this study and its contribution to understanding leadership in the NHS.

Chapter Five

Discussion

Introduction

This chapter begins with an examination of what nurses, nurse managers and executive team members in two health boards understand by the term leadership, what they value and what they consider important. Against this background the influence of environment, context and culture of NHS health boards is explored in which nurses and nurse managers are expected to accomplish leadership. The chapter goes on to explore a number of key themes in detail, an examination of the study's contribution, implications for policy and practice, and directions for future research. The chapter concludes with an examination of the study's limitations, and some reflections.

Summary of the study approach

This study began with the following aims, which were to:

- Explore how leadership and leadership behaviours within the NHS and particularly nursing function in practice.
- Explore what part the environment, context, organisational culture and the dynamics of NHS organisations play in how these behaviours and roles develop and function.
- Explore how these might help us understand the issues facing nurses, nurse managers and health boards in modernising and implementing new leadership roles.

These were addressed in two stages:

Stage one

A review of the literature published between 1990 and 2006 on leadership theory, leadership in the health service and specifically nursing, to assess what was already known about these areas and their possible relationship to organisational culture.

Stage two

Qualitative interviews in two health boards in Scotland to explore in depth perceptions of leadership and its relationship to organisational culture in practice.

Following data analysis the initial literature review described in chapter two was repeated using the same search strategy. In addition this was augmented with some additional search terms based on the study's findings.

The findings presented in chapter four are primarily an integrated account of informants' perceptions and their narratives. The section below provides a summary of those narratives followed by an exploration of key themes and associated literature. In presenting an overview of findings it is important to emphasise that data presented are the views of study participants in their own words which was largely in agreement, as opposed to conflicting or contradictory. While the account presented is based on the researcher's interpretation of study participants' views, other accounts are possible; e.g. ones that are suspicious of participants' views.

An overview of findings

Leadership in the health service is a complex issue because of differing structures, professional groups and effects of recent government reforms, which have emphasised the business side of healthcare rather than focusing on patients' needs

and service development. This has had a substantial effect on the context in which leaders function, on leadership and leadership behaviour. Environments have become more reactive and focused, with an increased emphasis on targets, risk management, governance, safety and the need for change. Local contexts increasingly operate a command and control philosophy not conducive for leadership to develop and flourish. Conflicting and competing priorities have created tensions calling for empowering and participative styles of leadership whilst maintaining directive and authoritative styles of management. Despite government requests for change and development, transformational leadership is not considered a priority valued by managers; emphasis is instead on quantitative delivery and transactional behaviours. Some feel there has been increased leadership and change only where investment has been made in specialist roles. This is in stark contrast to core services where leadership is felt to have been neglected.

Leadership development is perceived as developing individuals rather than developing leadership within organisations or leaders' roles in organisations. Use of the word leadership has increased together with types of leadership to more distributed forms and roles; leaders are now expected to be empowering and enabling in roles which are complex and multifaceted. Formal, informal and hybrid roles are identified as commonplace, each requiring different skills, styles and behaviours. Senior roles place emphasis on providing values for the culture and tone of organisations, whereas less senior roles are about motivating and supporting individuals and teams.

Leadership in nursing is seen as particularly challenging because of historical differences within the profession and the increasing nature of hybrid, mixed management and leadership roles. Clinical leadership brings particular challenges in relation to tensions between professional, clinical, managerial and organisational expectations and values. What nurses emphasise as 'having to be done' differs

from what they often feel 'should be done' and what is valued by clinical staff. Two critical aspects of leadership are emphasised; firstly what is done but secondly, and most importantly, how it is done; how leaders respond to the environment and how they approach and carry out their roles. Both are considered critical and are thought to hinge on leaders' abilities to interpret what is important and what will work in certain situations. Being a good role model and demonstrating valued characteristics, styles and behaviours is regarded as being of paramount importance.

Most when interviewed identified those characteristics associated with leadership: integrity, credibility, courage in making a stand in principle, self-awareness, the ability to engage with and relate to people in differing situations and contexts. These are all part of a leadership style which relates more to approaches and behaviours: how leaders demonstrate their attributes in practice by dealing with people and situations. Many placed emphasis on the 'softer' more human elements of leadership, whether they were "good with people". Despite the importance placed on these leadership styles and behaviours by staff the fact that they are not assessed or monitored seems to demonstrate the lack of importance placed on these by organisations. Different behaviours are thought to be required at different levels within organisations; all roles may adopt similar principles but how these take shape differs according to contexts and pressures.

Certain factors are regarded as particularly important in facilitating leadership: team support, support from the top of the organisation, reflection, role models, investment in leadership, structures, environment and culture, the ability to take risks and be creative. These are also regarded as some of the most constraining. Currently environments are not seen as supportive or conducive to learning but more focused on blame and mistakes. The need for clear structures, boundaries, responsibilities, expectations and accountability are emphasised as is the difficulty of balancing leaders need for support with ensuring appropriate freedom to act.

Investment in leadership development is considered key and a clear set of factors are associated in learning leadership: role models, experience in handling difficult and different situations, working with people, developing self awareness. The need for leaders to be able to exercise judgement and intuition in handling people and situations is regarded as critical. Attention should be paid to succession planning, in depth assessment of roles and skills required, improving the selection of leaders and the concentration on transformational aspects as opposed to technical expertise.

Organisational culture in this study is considered to be a combination of the characteristics of the people in the organisation and their styles of leadership. It consists of behaviours and environments underpinned by values, which form certain styles and behaviour. A number of factors are identified creating a positive organisational culture. These include; valuing staff, listening and enabling, being in touch with the organisation and its procedures, having defined goals, gaining respect and working as a team. Of particular note is how the organisation approaches risk and whether it is regarded as a learning organisation. Factors identified as unhelpful include inconsistent messages and differences in espoused behaviours and reality. Information on organisational culture is gained through learnt and unspoken behaviour. Both leadership and culture are viewed as inter-related with one influencing the other and culture is perceived as particularly important to leaders in exercising their role. Organisational culture was described as underpinning the context and environment and was referred to as being formed from long term effects of leaders' values and behaviours. What was perceived as having more immediate effect was local environment and context, thought to be a symptom of underlying culture of organisations and considered to be driven by leaders' values, particularly that of the chief executive and top management team. The roles of chief executive and top management team are seen as the main influences on the development of organisational culture and leadership and on determining the relationship between the two. They are considered to do this by;

setting the tone for how the organisation functions, its values and priorities, and by role - modelling how things are done. This affects how other leaders are able to work both in terms of what they do but also how they do it. Staff then make judgements as to what is perceived important both in relation to objectives and behaviour. This creates an important link between leadership, culture and values. In order for staff to want to work 'beyond expectations' they need to be able to relate to their leaders, their values and subsequently their style of leadership.

Examining key issues

Having considered a broad overview of the findings the relationship and interplay between leadership, context and culture becomes very apparent as does the difficulty of separating and considering these in isolation. This may account for the absence of empirical data particularly in relation to context and culture where they are often considered as secondary factors rather than as the subject of study in their own right. Before isolating a number of issues for further discussion it is important to consider generally how participants viewed and applied meaning to the concept of leadership in the NHS.

What does leadership mean in the NHS?

Leadership appears to be a broadly used term in the NHS. However this thesis suggests it consists of two distinct components; leader and leadership. The term leader relates to individual people who have or develop characteristics, styles and behaviours which allow them to exercise leadership. The term leadership relates either to how individual leaders influence and interact with staff, the organisation and organisational culture on a local level, or to leaders' roles within an environment, group or organisation. In the NHS, leaders need to work within organisations and therefore leadership is about an individual leader's ability to adapt (using skills and competencies) to circumstances and situations within the organisation. What is suggested by this study is that these terms although used

interchangeably, in practice, are different and require some similar but often very different skills and abilities which are dependent on role and where that role sits within the organisation.

This distinction has not been commented on in detail within the literature although a few authors do refer to differences (Rafferty 1993, Hunt, Boal and Dodge 1999, Gronn 2002, 2002a, Alimo-Metcalfe *et al*. 2008, Hannah and Lester 2009). In Rafferty's work two key themes emerged: leadership as a constellation of attributes and qualities and leadership as a process of influence and managing change. The nature of this influence and the opportunities to exercise it are said to depend on the situation and the task in hand and the characteristics and needs of the group in question. Hunt discusses multilevel leadership referring to leadership of organisations and leadership in organisations and Gronn considers a framework for understanding distributed organisational leadership claiming that leadership is about collective effort rather than the role of individuals. This point is reinforced by Yukl (1999) who prefers not one individual who can perform all essential leadership functions but a set of people who can collectively perform them. Hannah and Lester's theoretical paper proposes that leaders work at three levels; individual (micro level), network approach (meso) and a macro or systems level using specific leadership and management practices. These authors have made a distinction between leading and leadership inferring a difference between formal leadership roles, more concerned with, and more likely to influence, generic social interactions. Alimo-Metcalfe and Alban-Metcalfe (2001, 2005, 2006) make reference to 'near and far' leadership and to important differences also between the two. Within the NHS this is an area that has received very little study. This work supports Alimo-Metcalfe and Alban-Metcalfe's propositions and also proposes differences in types of leadership between hierarchical levels in organisations and to two linked, but distinctly separate components to leadership.

It is argued here that focus in the NHS until recently has been on individual leaders rather than on leaders' roles in organisations. Concentration therefore has been on the development of individual competencies and competency-based models of leadership. Increasingly evidence has highlighted the simplicity of assuming that just being competent in a range of activities is adequate for gaining the cooperation of individuals and for enabling and facilitating effective leadership and change in complex organisations such as the NHS (Alimo-Metcalfe and Alban-Metcalfe 2006, Alimo-Metcalfe *et al*. 2008, Bolden and Gosling 2006, Hollenbeck, McCall and Silzer 2006). These criticisms are well supported here and the findings also support those who claim these models fail to take into account the relationship and role of environment, context and culture (Wood and Gosling 2006). The subsequent development of the NHS Leadership Quality Frameworks which describe a set of key characteristics, attitudes and behaviours that leaders in the NHS should aspire to has also been criticised for its concentration on individuals, with commentators considering it an inappropriate model of leadership to be applied to the entire NHS (Alimo-Metcalfe *et al.* 2008, Wood and Gosling 2006). These criticisms are based on methodological and epistemological concerns. Firstly the framework's aim was to provide the foundation for developing high performing leaders at all levels in the NHS. However the study only incorporated data from interviews with fifty chief executives and four directors (Wood and Gosling 2006, Macdonald, Price and Askham 2009). Secondly, it exclusively focused on personal qualities. An additional criticism following the work reported here is that the characteristics and behaviours emphasised as important within these frameworks, whilst there are similarities, do not correlate with what staff value, which is also supported by other recent research in this area (Alimo-Metcalfe *et al.* 2008, Stanley 2006, 2006a 2006b, 2006c, 2008).

A number of aspects in this study are particularly noteworthy and appear to underpin practitioners' understanding of leadership, influence behaviours and

provide other perspectives when considering theoretical models, practical considerations and applications. These can be summarised as:

- *The role of values in leadership*
- *What staff identify as being particularly important in relation to leadership*
- *How leadership is affected by context and culture leaders find themselves in*
- *The relevance of theoretical models*

These aspects will now be considered in more detail in relation to the literature including: the initial literature review; additional research published since 2006 and leadership theory (some of which has already been reviewed in chapter two).

The role of values in leadership

In this study, values were reported to play an important role in relation to leadership, perceptions of leaders and respondents' behaviours. Leaders' activities implied certain values which mattered and appealed to respondents influencing their opinions and behaviour. They appeared to reveal insight into what personally drives leaders and what they see as important. Respondents seem to decide intuitively if the leader has similar values to their own, influencing their opinion as to whether this is someone they can identify with. Although respondents were not asked to define or directly discuss values in any depth they clearly referred to three types; personal, professional and organisational.

Literature in this field often does not make these distinctions and many of the studies conducted do not provide definitions although many assume those based on interpretations of charismatic leadership. According to Sosik (2005) values represent notions of what ought or ought not to be, having both content and intensity attributes specifying what is important (content) and how important the value is (intensity). Ranking of a person's values in terms of their intensity

therefore reveals the person's value system with its interrelated value components that interact guiding the person's behaviour (Rokeach 1973).

We could perhaps assume that values would play an important role in the NHS as it is largely full of professional people who tend to come through training with a strong value base. Respondents in this study appeared to have tacit assumptions as to what a leader should be based on a mixture of personal, professional and organisational components. They assessed whether what they heard and saw matched their own vision or ideas, values and expectations. This was particularly apparent when one director described processes she went through in deciding whether to accept a post in that organisation. These were summarised as being; whether or not she identified with the chief executive's values; whether or not she would fit into the organisation and whether she could work with its people.

Despite values appearing to play an important role as a broad concept they have only been explored in a few studies with relatively few, if any, taking place in healthcare. Empirical studies are generally from the US involving the military, students and managers. Offerman, Hanges and Day, (2001) provide a useful overview and a US study by Dickson, Resick and Hanges (2006) make an important contribution. Although values were not the main focus of the research the literature review and discussion cite some interesting issues a number of which support findings in this thesis.

Data in Dickson, Resick and Hanges's study were collected as part of the Global Leadership and Organisational Behaviour Effectiveness Research Programme (GLOBE 2004), a long term multi-phase, multiple method project investigating ways in which societal and organisational cultures and subcultures relate to leadership and organisational practices (House *et al.* 1999, House 2004). Within the review authors comment on some of the most significant work in this area which suggests; firstly that when employees join organisations they already have

some degree of similarity with current organisation members in beliefs, values and perceptions; secondly that there is generally similarity in the prototypes held by organisational members and thirdly that prospective employees check out leaders' values prior to accepting posts as indicated in this study. Dickson Resick and Hanges's literature review makes four statements, two of which are particularly relevant; firstly that people choose to join organisations in which they think they will fit in and secondly that eventually organisational members start to share beliefs, values and agreement on types of leadership which differ from members of other organisations. Owing to the link with values and behaviour, authors claim this leads to similarities across, and differences between organisations on several dimensions, which probably includes types of leadership. It is acknowledged that these do not develop independently of organisational structures, strategies and cultures which they suggest have a substantial impact on the types of leaders that are viewed as effective and thus the types of leadership generated by members in a particular setting, which is further substantiated by this study.

Dickson, Resick and Hanges claim a number of important findings. Firstly, types of effective leadership are shared among members of organisations. Secondly, these are based on organisational form such as shared beliefs about leadership and culture. Thirdly the content of shared types of effective leadership varied according to whether or not organisations were rated as developmental (organic) or more business orientated (mechanistic). The most relevant finding was the overall influence of contextual factors such as structures, processes, climate and culture, likely to affect the types of leadership generated in the organisations studied. What is indicated is that perhaps types of leadership are affected by perceptions of how organisations operate and exposure to different types of leadership, which may develop shared thoughts and perceptions of organisations, what is effective in terms of leadership and shared values and beliefs.

In this work interviewees claimed that staff looked for leaders who pursued goals, which fitted with their values and demonstrated these values in their work. Whether or not and indeed how leaders demonstrated these appeared critical and linked to a 'likeability factor', which respondents then used in determining a preference for certain leaders, which related to their choice to respect and support certain people. This was evidenced in numerous quotes exemplifying the need to be on the same wavelength as their leader, discussions identifying and outlining properties they valued and in their criteria for selecting role models. Recent work has found self-concordance (defined as the pursuit of goals aligned with one's own values, Cha and Edmondson 2006) to be positively associated with outcomes including job attitudes and performance. These findings are substantiated by Ehrhart and Kleins study (2001) which suggests that followers prefer to form relationships with certain types of leader if given the opportunity to do so. Respondents implied that a leader could demonstrate particular valuable characteristics, but if they failed to articulate their values and what they stood for or were not seen to demonstrate these it was unlikely they would be held in the same regard as a leader that did. Many discussed the importance of leaders 'doing what they said they'd do' and this informed whether or not they were seen as credible, were respected and therefore followed by others. This observation was supported by Burgoyne and Lorbiecki (1993).

Much has been made of two particular components of transformational leadership by recent authors (Shamir and Howell 1999, Cho and Dansereau 2010, Szabo *et al*. 2001, Lord and Brown 2001, Sosik 2005). These components are idealised consideration and idealised influence or charisma which relates to values. According to Bass and Riggio (2006) a transformational leader's charisma consists of two behavioural components: idealised influence and inspirational motivation. Idealised influence includes a leader's emphasis on the importance of having a collective mission. In order to achieve the collective goal a leader should be willing to take risks, show self sacrificing behaviours and demonstrate high standards of

moral conduct. Inspirational motivation describes leaders' abilities to inspire followers by outlining a compelling vision of the future, providing meaning and challenge for their work. These behavioural characteristics motivate followers to transform their own interests into group interests for the sake of the collective benefits. They do this by influencing followers' values, ideas and beliefs (Conger and Kaunugo 1998, Shamir, House and Arthur 1993).

Specifically, House and Shamir (1993) define charismatic leadership as an interaction between leaders and followers that results in making followers self esteem contingent on the vision articulated by the leader. This then brings strong personal or moral commitment to values and goals and a willingness of followers to rise above their self interests for the sake of the team or organisation. This was demonstrated in this research where respondents clearly valued leaders who were able to articulate their values and thoughts and demonstrate these in their behaviour. However what differed was the lack of importance placed on vision. Both of these factors were identified by writers like Stanley (2006, 2006a, 2006b) and Dasborough and Ashkanasy (2002) who also suggest that the success of charismatic leadership seems associated with followers' subjective assessment regarding a leader's motives. Another interesting point in this thesis was the particular importance placed upon this style of leadership at senior level; resonating with much earlier research in this area (Bryman 1996).

Despite values playing a central role in charismatic leadership they have only been explored in a few studies Sosik (2005), Cha and Edmondson (2006), Lord and Brown (2001), Ehrhart and Klein (2001). It remains unclear as to which values are mostly associated with the leaders or to the relationship of values to behaviours. Little work has been done in the NHS, although Stanley's work on clinical leadership is directly relevant (2006, 2006a, 2006b, 2008) and is discussed later in this section. It seems that values related to charismatic leadership predict managerial performance. Managers who hold strong beliefs and values appear to be highly

regarded, but possible tensions exist between values such as business efficiency and those that emphasise the welfare and needs of employees. What is interesting to note is the lack of importance associated with values directed towards vision and change, revealed by this thesis and supported by theories of charisma and values - based leadership (House 1996, Gardner and Avolio 1998, Shamir, House and Arthur 1993). Values influence vision, leaders and followers. Results also provide support for the propositions of several transformational leadership perspectives, which predict that leaders who use inspirational leadership and role models empower followers to perform 'beyond expectations' (Bass 1985, Burns 2003, Conger and Kanungo 1998). There are however several limitations: in some cases measures were based on charismatic leadership only; samples consisted only of managers from the US and questions can be asked about their applicability to the UK health sector with its different culture and structure.

It appears little work has been done on the relationship between values and behaviour. Lord and Brown's theoretical paper and review (2001) explores the links concluding that values are linked to personal identities and have mutually re-enforcing effects on motivation. Culture and context play important roles in linking motivation and behaviours. Whilst leadership and motivational interventions can be focused on objectives, a leader's influence will be greater if leadership actions are focused on values and identities. In previous work Lord, Brown and Freiberg (1999) suggest that leadership works best when there is a match between followers' identities and the focus of leaders. In this paper this thinking is expanded to include values, noting that there are clear patterns of values that correspond to individuals and that leadership activities imply certain values, which fit particularly well with comments made here. Also highlighted was the leader's need to be consistent in values they stress and lack of congruence can present issues for followers in identifying with certain leaders.

The study provides a useful definition of values (Schwartz 1992:2) as; *"desirable states, objects, goals or behaviours transcending specific situations and applied as normative standards to judge and to choose among alternative modes of behaviour."* This definition ties values to behavioural choice and highlights two important functions of values; firstly values can provide coherence and a sense of purpose to an individual's behaviour and secondly as normative standards, values are a basis for generating behaviours that conform to the needs of groups or organisations. In this study leaders influenced individual and group action by highlighting the relevance of behaviours to important values. The study presents a model relating values and identities and proposes that identities organise values and values on behaviour.

Szabo *et al.'*s (2001) article also considers this relationship comparing empirical findings from other studies. Findings indicate a complex relationship influenced by cultural factors. This thesis suggests a definite relationship influenced by other factors such as the importance of "nearby leadership", engagement; social interactions and particularly professional and organisational conflict.

In this study it appears that to an important degree leadership is a perceptual phenomenon. Respondents observed words and actions of their leaders and appeared to make inferences about their motives. This is supported by O' Reilly *et al*. (2010) where perceptions were associated with variations in objective or organisational outcomes suggesting that how employees see and interpret the behaviour of leaders can be an important motivator for performance. Recognising this Polony, Khurana and Hill-Popper (2005:47) have argued that leadership is explicitly about those words and actions that create meaning for employees. Given the findings in this thesis, this could be linked to values, perceptions of credibility or to how many leaders demonstrate qualities that staff value. One of the most prominent issues in discussions was the conflict and tension between what could be termed the developmental or transformational agenda and the more managerial

and transactional. Respondents provided a professional or clinical view to their perceptions, decisions and judgements in assessing leaders' value, capability or effectiveness. This included whether what leaders said made sense, whether they thought it important, whether they were knowledgeable, credible and honest, and demonstrated an understanding of the issues. Degeling and Carr (2004) raised the importance of considering attitudes, values and beliefs of clinical staff and complexities of professional roles in the health service, which form a particular context and culture for the NHS. Results from his study and others (Stanley 2006, 2006b, 2008) point out that staff value people with similar views and in the NHS this appears to centre on a clinical care model versus more technical or transactional models.

These tensions are supported in recent literature on clinical leadership (Hewison and Griffiths 2004, Degeling and Carr 2004, Worthington 2004, Edmonstone 2008, Mallak *et al.* 2003, Forbes, Hallier and Kelly 2004, Burgoyne and Lorbiecki 1993, Kippist and Fitzgerald 2009) reinforcing distinctions between clinical and managerial leadership suggesting that motivations of clinicians are different and are based on values geared towards the needs of patients as opposed to managerial objectives which are perceived to be about achieving targets and the needs of organisations. Also supporting this Glouberman and Mintzberg (2001) introduced a framework for viewing what Kippist and Fitzgerald describe (2009: 645) as "the four worlds of healthcare": "Cure" focuses on doctors' interventions with patients; "care" focuses on the coordination of care by nurses; "control" via administrative hierarchy and "constraint" by hierarchical management boards of the hospital. Kippist and Fitzgerald refer to the care and cure domains as representing the "practices of health" and the control and constraint domains as being the "business of health" (2009:645). Although this framework shows clear distinctions between these domains, Kippist and Fitzgerald argue that these divisions are far from clear and that because of the often unclear boundaries between roles and relationships in organisations these are often difficult to identify and separate which is what causes

difficulties and tensions. The paper emphasises that both clinical leaders and managers share some common values and objectives, particularly in the practice of health and in improving services and patient care. However it suggests that an area where objectives may differ is in the business of health where management practices are often concerned with efficiency targets and achieving savings which could be seen by clinicians as compromising patient care and therefore as conflicting with their professional values. This is supported by respondents in this study who referred to dilemmas of having to decide between the two agendas. Leaders were then judged by staff on how they handled this.

Recent studies have discussed these tensions specifically within nursing (Christian and Norman 1998, Stanley 2006, 2006a, 2006b, 2006c, 2008, Hewison and Griffiths 2004, Firth 2002, Naughton and Nolan 1998, Moody and Pesut 2006). Naughton and Nolan draw attention to potential tensions between "new nursing" with the change of focus and the introduction of "scientific management" (1998:964). One (new nursing) aims for total patient care delivery while scientific management emphasises profitability and throughput and favours a more routine approach to care. Authors highlight that while nurse education emphasises holistic and patient centred care in reality nurses have to practise in an environment dominated by efficiency targets and financial constraints (1998:964). It can be claimed that people are influenced by their values and beliefs and these shape how individuals see the world and the meanings they attribute to their experiences, actions and relationships with others. This is particularly important in nursing as it provides a sense of purpose and offers worthwhile meaning to doing the job.

A study of ward managers (Firth 2002) introduced the notion of cognitive dissonance defined by the author as: *"psychological conflict arising from having to perform incompatible roles"* (Firth 2002: 489). All participants were said to experience a constant theme of internal conflict between managerial and clinical sides of the role. Building on this theme Forbes and Hallier (2006) highlight that

clinicians historically have been trained along narrow professional lines which often have taken no account of wider inter-professional and organisational factors within healthcare organisations and this can lead to a degree of tension between professional values of their clinical roles and the autonomy they enjoy and organisational and management demands for improved efficiency and accountability. One of this study's respondents, a chief executive, admitted he actually didn't want nurses working autonomously as it would risk routine care delivery.

Of particular relevance are the recent commentaries and study undertaken by Stanley (2006, 2006a, 2006b, 2006c, 2008). He proposes that, traditionally, leadership in nursing has been based on notions related to nurse managers' positions which he claims are not necessarily transferable when seeking to understand clinical leadership positions. He says the drive to place clinicians in key leadership roles has been hindered by a misunderstanding about the differences between leadership and management. His study (2006a) reveals that these differences and the problems that arise from them are issues that nurses are very aware of, findings which are supported in this research. In his study in 1993 Forbes suggested that traditional managerial tasks were best done by administrators because these tasks tended to interfere with the clinical focus of senior nurse clinicians. His study's findings are supported by Doyal (1998), Firth (2002), Naughton and Nolan (1998), Hewison and Griffiths (2004) and Stanley (2006). In all these studies the same issues and tensions were raised, particularly related to conflict between professional and clinical values. This is now also supported by findings in this study.

As pointed out by Stanley (2006:32) the regularity with which issues of professional role conflict and blurred boundaries feature in the literature perhaps should point to a fault in the structure of nurse manager / leader roles and helps to confirm that, within the NHS, clinical leadership and management are two separate entities. As

well articulated by Stanley, most nurses become nurses to care for patients and progress into management or leadership roles to try and improve patient care. Their values are based on promoting high standards of care and treatment. Therefore they are pulled to work in different ways which is revealed again in this data set. What is particularly evident is the difficulty in having both clinical and managerial elements to roles; whether this is via actual patient care delivery or by being responsible for clinical care delivery and development. Where conflict appears to arise is when managerial responsibilities dominate leaders' perceived effectiveness and in this study was more evident the more senior the role. The aim of Stanley's study and his subsequent commentary (2008) was to identify who clinical leaders are and then to analyse experiences of being a clinical leader. The study was qualitative using grounded theory and two principal methods to generate data: a questionnaire and two phases of interviews. Findings from this study fit in well with the claims of this thesis. In summary some of the key points are outlined below.

Firstly a particular set of attributes are associated with clinical leadership which differ from traditional leadership models but which correlate with recent studies in this area. These are that clinical leaders are approachable, good communicators, inspiring as role models, visible, clinically competent and knowledgeable, decision makers and most importantly motivators who demonstrate their values and beliefs about nursing and care in their approaches, practice and behaviours. Many of these are similar to findings in other studies emphasising clinical leadership (Harper 1995, Cook and Holt 2000, Cook 2001, Schneider 1999). These are all qualities emphasised in this research stressing the human and personal elements of leadership. However differences are also apparent both in content and emphasis. This study would emphasise engagement, creativity and self awareness, factors also well supported in other literature (Cook 2001, Antrobus and Kitson 1999, Alimo-Metcalfe *et al*. 2008). Secondly another significant difference pointed out by Stanley (and supported by previous literature already discussed) is that his study

listed clinical expertise, effective communication, empowerment and a desire to provide quality care as particularly important. Not at any point was vision identified as an important attribute. This fitted in with the replies of respondents in this study who mentioned it as a key feature of leadership but not an attribute valued or that motivated staff. Instead it was the demonstration of values and beliefs and their translation into actions and roles for which they are respected and therefore followed. This was confirmed in Stanley's study via data gathered in both questionnaire and interview.

Thirdly; based on these findings Stanley proposes 'congruent leadership' as the most appropriate leadership theory to support an understanding of clinical leadership: clinical nurse leaders are followed because there is a match between the leaders' values, beliefs and their actions. Clinical leadership is therefore based on *"where leaders' stand, not where they are going"* (Stanley 2008:522). A view linking values and vision is proposed by Pendleton and King (2002) who declare that it may be more important to know where you stand (described by Stanley as a values centred position) rather than where you are going, pertaining to vision. This implies that values are rooted in understanding an individual's or organisation's principles, while vision is about being able to drive through or respond to changes in the future. Values and vision do appear connected but may point to motivations driving individuals and organisations from different perspectives. This was evident in Manley's studies (2000, 2000a,) where her values supported and matched her actions and this congruence formed the basis for her success as a clinical leader. Manley (2000a) also recognised that her leadership brought about 'cultural change' because her values were used to highlight the contradiction between espoused culture and culture in practice (2000a:34) and as Stanley points out changes were achieved not by transformational leadership but more by her actions than her vision.

In summary then, personal, professional and organisational values are important in leadership in their relationship to leaders, followers and behaviours. How these are demonstrated is a key feature. Values appear to play a particularly pivotal role in clinical leadership where respondents suggest they directly influence how practitioners view leaders. As this study was not exploring or asking questions about values directly however, no definitive comments can be made, but results would suggest that these play an important part in making judgements about leaders. Values and leadership style however have been shown to differ based on culture and organisational context (Bass 1985, Schwartz 1992) and have a substantial impact and on whether leaders are seen to be effective, linking in how these characteristics, values and behaviours are utilised within wider organisations. As many studies have not incorporated situational factors the specific role of culture, context and values is unclear. Having identified values as an important driver in leadership, respondents in this study clearly value particular characteristics, styles and behaviours.

What characteristics, styles and behaviours are important to staff?

This study has emphasised specific characteristics, styles and behaviours such as: listening and engaging, integrity and emotional intelligence, communication and interpersonal skills which are listed in full in the findings chapter. These have been endorsed by many other authors, particularly: Alimo-Metcalfe *et al.* 2007, 2008, Sellegen 2007, Stanley 2006, 2006a, 2006b, 2008, Storr 2004, Akerjordet and Severinsson 2008, Jahrami, Marnoch and Gray 2009, Cook 2001, Jennings, Scalzi, Rodgers and keane 2007, Moody and Pesut 2006, Yang and Mossholder 2010, Norman, Avolio and Luthans 2010, Buchanan *et al.* 2009, West *et al.* 2003. One or two of these properties have been commented on in detail revealing connections with other factors such as trust linked with integrity and emotional intelligence with interpersonal skills. The findings particularly fit with Alimo-Metcalfe and Alban-

Metcalfe's studies (2001, 2005, 2005a 2006) into the nature of leadership in UK local government and the NHS discussed in the literature review. The model that emerged was one of 'nearby' leadership that reflects an 'engaging' style of leadership. This is defined by Alimo-Metcalfe *et al*. (2008) as a style of leadership that shows respect for others, concern for their development and well-being, engages others in developing a joint vision, creates a development culture, empowers and develops potential and encourages questioning and critical thinking. It is based on integrity, openness, transparency and valuing others, being decisive and able to resolve complex problems. Behaviour is guided by ethical principles and the desire to achieve a shared vision (Alimo-Metcalfe *et al*.2008:587).

In line with this thinking in this study two factors play particular importance: trust and engagement. Staff perceptions of trust seem essential to the process of leadership and based on findings here as with values, leader behaviours appear to engender trust which affects practitioners' attitudes, perceptions and reactions. Leaders appear to instil trust in staff by being explicit about intentions, expectations and how they intend to approach objectives. These then affect their relationships and interactions. Respondents spoke about the importance of trust particularly with their line managers and their immediate environment as opposed to the wider management team. This is understandable as line managers have more immediate influence on a day to day basis than distant leaders who have a more broad based impact over time through setting objectives and directing resources but need practitioner "buy in".

The link between trust in leaders and employees' attitudes and behaviours can be readily seen in the literature (Yang and Mossholder 2010, Dirks and Parks 2003, Pillai, Schriesheim and Williams 1999). What appears less clear are the motives explaining why employees are willing to trust leaders to a greater or lesser degree. Yang and Mossholder's (2010) research claims that two psychological processes underlie employees' trust, one instrumental and one relational. One focuses on

another party's characteristics such as ability, dependability and integrity and the latter derives more from personal relationships, both evident in this study. An American quantitative healthcare study (there are no reasons to suggest results are insignificant) underlines the importance of interpersonal interactions with leaders in motivating and energising positive work behaviour, and the importance of a leader's role in fostering trust through explicit articulation of values, intentions and approaches. Respondents in the study stressed other important characteristics aligned with trust such as integrity, interpersonal skills and the importance placed on the strategies leaders adopt in the situations they find themselves in.

Norman, Avolio and Luthans (2010) and other writers (Avolio and Gardner 2005, Avolio *et al.* 2004) deal with concepts of positivity and transparency and claim that a leader who displays high levels of positivity would be seen by others as being more competent and in turn trustworthy because these components have been demonstrated to be connected to higher levels of performance. This is not something that respondents dealt with here. However the importance of transparency was a factor frequently referred to either in discussing integrity and honesty or implied implicitly when 'judging' leaders' values and behaviour.

Building on her previous work Alimo-Metcalfe *et al*.'s recent study (2008) deals with the importance of "engagement" and examines the relationship between quality of leadership and staff attitudes to work, their well-being at work and organisational performance. Engaging with others was shown to be a significant predictor of organisational performance and leadership ability assessed by competencies or capabilities was not. As pointed out by the author it is interesting to note where significant relationships were lacking. Neither shared vision nor leadership capability was linked to attitudes at work, only motivation to achieve. In attitudes to work and wellbeing at work engaging with others was found to be highly significant with much less significance attached to leadership capability and shared vision. The study is important for a number of reasons. Firstly it demonstrates

what kinds of leadership behaviours are effective or considered unhelpful or harmful; secondly that leadership culture and capability are both important indicators of how leadership is perceived by staff; but thirdly that the greatest leadership qualities valued by staff and greatest single influence on performance are behaviours linked to engaging with others and establishing a shared vision. Where staff perceive leaders as engaging by being involving, supportive and loyal, then positive attitudes to work and a sense of well being at work result. It appears attitudes to work are affected predominantly by a combination of concern for how staff are treated and leadership capabilities, particularly having clear expectations and processes. A culture of engaging with staff engendered one of risk taking, learning and innovation.

Given Stanley's recent studies discussing differences in clinical leadership it is interesting to note that findings from almost all recent studies are consistent particularly emphasising listening and engaging with staff, building trust, values and self awareness in addition to the importance of clinical competence and knowledge (Stanley 2006, 2006b, 2006c, 2008, Jahrami, Marnoch and Gray 2009, Cummings *et al*. 2008, 2010, Sellgren 2007, 2008, Akerjordet and Severinsson 2008). Particular features of congruent leadership, as identified by Stanley, are leaders who are inspirational, approachable, open, visible, empowering and supportive. They are people of integrity, decision makers, role models, good communicators. Stanley makes the point that these are not transformational leaders as they are not characterised by vision, also evident here in this study. Notably in Jahrami's study shaping vision and direction were also ranked towards the bottom of the managerial qualities. However almost all of these elements comprise components of two aspects of transformational leadership: idealised consideration and idealised influence. There is a possibility therefore that the main differences as highlighted by Stanley are the emphasis on and links to values. It would be useful therefore to explore how leaders perceive leadership within the NHS in a non clinical sample.

As in this study, Stanley and Alimo-Metcalfe *et al*., information collected in Jahrami Marnoch and Gray's study related to personal qualities honesty, fairness, humility, kindness and resilience. Few differences were noticeable between hierarchical levels. In Selligren (2007) visibility of managers was seen as particularly important which could indicate this is important to clinicians. Respondents in this study did not see it as a significant issue. These differences could relate to sample differences: and might suggest visibility is less important the more senior you are. Authors conclude that followers prefer managers with clearly expressed leadership behaviour. In this study importance was also attributed to different characteristics and behaviours being valued at different levels within the organisation. This is something that does not appear to have been studied a great deal but has important implications as it points to the need for different styles and behaviours at different levels in the organisation.

Cummings *et al*. systematic reviews (2008, 2010) show some correlation with this study's findings particularly the importance of visibility and accessibility, "nearby" leadership, self efficacy, leaders' roles in role modelling and demonstrating leadership skills during the course of their work. Particularly emphasised are: the importance of transformational and relational styles of leadership, high levels of emotional intelligence and leaders' ability to 'tune in' to staffs' emotional needs and concerns. Akerjordet and Severinsson (2008) also emphasise emotional intelligence, self awareness, self confidence and empathy as important components of nurse leadership. Characteristics highlighted as important include teamwork, building relationships, collaboration, mentoring, respect, and open communication which all have high resonance with other factors discussed. What is interesting is that authors feel that emotional intelligence within nursing leadership reflects a different leadership style which emphasises personal reflection, wellbeing, strong relationships, pursuit of common goals and co-operation. They consider nurse leaders with high emotional intelligence act out of commitment to their own values. Links can therefore be made to values.

An important factor to note is the wealth of recent research linking leadership characteristics, styles and particularly behaviours to job satisfaction, low staff turnover, commitment, wellbeing, organisational and staff performance, patient satisfaction and work climate (Sellegren 2007, Borrill, West and Dawson 2005, Alimo-Metcalfe *et al.* 2008, O' Reilly *et al*. 2010, Podolony, Khurana and Hilpopper 2005, Moody and Pesut 2006, Kenmore 2008). Strong links can be made to particular valued characteristics seen in this study. Some of these studies in nursing (Moody and Pesut 2006, Kenmore 2008) suggest that nurses' motivation is enhanced by a level of autonomy which encourages moral practice and the ethic of caring. Employee engagement is linked to low absenteeism (Kenmore 2008, Cohen 1993, Barber, Hayday and Bevan 1999). The ward climate depends on the leadership styles adopted by ward managers. What is significant to note is in a number of these studies (Sellegren 2007) it is the human elements again which resonate and support this thesis and lead to increased job satisfaction and teamwork. Selligren's results show strong correlations between leadership behaviour and work climate and job satisfaction and seems to be the only study that explores effects of leader/manager behaviour in nursing on these matters. Park and Kim (2009) and Leban and Zulauf (2004) show association but not causation between improved performance and a positive work environment which emphasises values, human relations, trust, empowerment and emotional intelligence. The most important links to all these are leader behaviour.

What is also interesting to note for the purpose of this thesis is that these studies also found that characteristics and behaviours were linked to perceptions of leaders' effectiveness. Interesting links can be established therefore to values and the importance of ethical and moral dimensions to effective leadership and between perceived integrity and leader effectiveness. This strengthens the argument that leadership is a perceptual phenomenon.

What is particularly evident from this work then is that what is valued is not leaders with vision, but personal elements, character and behaviour. In valuing particular leadership qualities overall the importance of relationships, ethics and authenticity - orientated leadership is highly significant although many studies appear not to have looked at why. However this research and recent literature (Alimo-Metcalfe *et al*. 2007, 2008, Stanley 2006, 2006a. 2006b, 2008) suggest why these factors are important in the NHS and emphasise the considerable effect contextual factors can have on service delivery.

The effects of contextual factors in the NHS

Within the literature context and culture are perceived as playing a critical role in influencing leaders, leadership and leadership behaviour (Schein 1985). Within this study culture is seen as a long term outcome of behaviours associated largely with senior leaders. Context was described as more short term and more immediately influenced by 'nearby' leaders. What is emphasised is how values, characteristics and behaviours are linked to and affected by the context and culture in which leaders find themselves. Respondents said that although they could work in their own area as individual leaders influencing local context, this was difficult to sustain if it was contrary to overall organisational culture. This was particularly felt by senior managers or leaders. Degeling and Carr (2004) support this, challenging the notion that leaders can act on their own desires outside of organisational culture. Degeling and Carr's work revealed systematic differences in values, attitudes and beliefs between doctors and nurses; the former having a more individualistic view of clinical work and less of an organisational emphasis whereas nurses had a more collective and systemised view. This resonates well with this thesis where participants viewed doctors as having a perceived lack of ownership and engagement in the organisational agenda. This may suggest that organisational context and culture could affect nurses potentially more than doctors because of differences in roles, perceived autonomy and authority.

This study claims leadership development is not seen to equip leaders to work in organisations. Literature highlights this point stating that traditional leadership development trivialises conflicts that exist in organisations, ignoring the context within which leadership takes place and behaviours such as empowerment, risk taking and creativity (Goodwin 2000, Proctor, Currie and Orme 1999). Recent literature discusses interaction of contextual factors and leadership acknowledging that leadership is about individuals and their situations in organisations and their ability to diagnose and adapt their style to these (Millward and Bryan 2005, Hewison and Griffiths 2004, Silvia and McGuire 2010). Millward and Bryan also make the point that culture provides a framework for behaviour but does not determine behaviour itself. Behaviour is replicated through people.

In reviewing the literature in this area Porter and McLaughlin (2006) concluded of the 16% of studies considering organisational context and culture 44% were conceptual and 26% empirical. Emphasis therefore has been on discussion versus actual study. There appears no universal agreed set of concepts that comprise the context for leadership behaviour although reviews cited seem to have a consensus around the following components; culture and climate, goals and purpose, people and composition, processes, state/condition, structures and time. Most of these are important in leadership. Although for years studies have alluded to the importance and interplay of organisational context and leadership empirically there do not appear within this review and time frame any sort of consistent focused attempts to examine this relationship systematically. Almost half of empirical studies in this review were focused on transformational or charismatic leadership with the context either a secondary concern or just one of the many factors addressed. However context and culture are said to play a particularly important role helping to establish the environmental context that sanctions or discourages behaviour (Hambrick and Finkelstein 1987, Schein 1992, Trice and Beyer 1993, Avolio and Bass 1995). As previously referred to with respect to values results suggest that

individuals within organisations develop shared beliefs about leadership and the nature of these beliefs is related to culture.

This study emphasises the negative effects particularly on nurses and local contexts of targets and certain aspects of performance management which were said to reduce risk taking and creativity. Little work empirically appears to have been done to either support or refute these assertions. Nystrom (1990) found that organisational divisions were more innovative when their cultures responded to challenge and risk taking. Abbey and Dickson (1983) found that climate was the most important component for research and development. A related literature review (Shalley and Gilson 2004) discusses links between leadership and leadership behaviour that may enhance work context/environment for creativity. Although healthcare contexts differ from some of those discussed in Shalley's review it is of interest because of the little work done in this area and because it is creative thinking which leaders need to generate alternatives, engage in divergent thinking or make judgement.

Commentators highlight that creativity inherently involves risks and potential failure and this can depend on individuals' predisposition towards risk and organisational context. If employees or organisations are risk adverse it is easier for staff to continue performing in routine ways rather than take a chance with a new or different approach which is articulated in this thesis. A key link must therefore be to encourage people to take risks. Authors indicate that leaders need to concentrate on affecting the social and contextual influences in the work environment that would be most likely to lead to creativity when jobs are complex and demanding. Individuals then are more likely to consider different alternatives resulting in more creative outcomes. On the other hand jobs that are more simple and routine may not motivate employees or allow them the flexibility to try new things, to take risks or perform creatively. These points were discussed at length in this thesis. Respondents referred to environments not only as risk adverse but risk

intolerant, with one chief executive indicating that too much latitude and freedom to act could result in lack of standardisation of care potentially affecting performance. This suggests tensions between these two concepts. In support of this Shalley, Gilson and Blunn (2000) found that when the work environment complemented the creative requirements for the job, individuals had higher job satisfaction and less intention to leave - all factors highlighted in this thesis as facilitating leadership and context.

Whilst a considerable amount is known about personality characteristics associated with creative individuals (Amabile 1996) less is known about contextual factors that may enhance or discourage employees'/leaders' creativity or the interaction between personal characteristics and the work environment. Role autonomy (Bailyn 1988), expectations and goal setting (emphasised here as important), have been shown to be key in motivation and creativity by increasing attention and effort through providing clear targets (Locke and Latham 1990, Amabile and Gryskiewiez 1987, Pinto and Prescott 1988). This affects how people work and how long they persist on a task. Goals are more likely to be attained when people are strongly committed and are given feedback concerning their progress - again these are factors listed in this thesis as important in leaders' behaviour. Leaders must make clear what is valued by the organisation. Structures that promote open engagement and communication have also been positively linked to creativity (Ancona and Caldwell 1992; Dougherty and Hardy 1996). Other key components positively influencing creativity are rewards (Kerr 1975, Amabile, Goldfarb and Brackfield 1990), resources such as time (Amabile *et al*. 2003) and supervisory support (George and Zhou 2001). Scott and Bruce (1994) and Oldham and Cummings (1996) found that the quality of the exchange or relationship between a supervisor and his/her employees was related to employees' perception of the existence of an innovative supportive climate and that supportive non - controlling supervisors created a work environment that fostered creativity. In this thesis role modelling was considered important as was creating an overall team environment

which supports and encourages creativity. This has been referred to in the literature as providing a culture where employees 'feel safe' so that blame and punishment will not be assigned for new ideas or breaking with the status quo (Blake and Mouton 1985, Edmondson 1999).

Amabile, Schatzel, Moneta and Kramer (2004) focused on two team leaders with their respective teams and their interaction to see how a leader's actions encourage and motivate. The less positive team was described by participants as micro-managed, autocratic, not involving or empowering, having a lack of trust, with the leader questioning team actions and behaviours. The positive example presented the opposite. The team was consulted, involved and worked together to set goals and priorities. One leader was seen by staff to support the team with upper management the other was regarded as colluding or being more on par with management than the team. This was also emphasised by respondents in this thesis as critically important to the role of leader. The study suggests that a leader who interacts daily with the team influences their perceptions, feelings, performance, environment, and creativity.

The study suggests the impact of the perceived work environment on creativity, of leader behaviour and its influence. How well or poorly leaders do this is key. Effective leadership behaviours appear to require skills in both relational and task - orientated work and what is critical is the ability to be able to integrate the two successfully. Leadership behaviours such as monitoring, clarifying roles and objectives, and consultancy appear to be particularly important certainly in creativity and creating a positive environment. When people are valued, supported and given some autonomy, leaders were perceived positively - all of which affected the environment and promoted creativity. These findings are consistent with situational and path - goal theories of leadership around valuing involvement and adjustment to situation and issue (Hersey and Blanchard 1969). The study also illustrates the importance of qualitative study and particularly of collecting narrative

data over time. Limitations though with naturalistic study include the inability to prove causality. The study however emphasises links between leadership and context and that particular behaviours deserve particular emphasis.

Context and culture also featured as a key issue in discussing facilitators and inhibitors to leadership in this work. Little empirical work has taken place on this in the health service but what has been done shows the positive results of teamwork, support from line managers and peers, and good leadership particularly at the top of the organisation (McCabe and Garavan 2008, Buchanan *et al*. 2009, Kan and Parry 2004). Kan and Parry's results via use of the MLQ indicated that nurse leaders displayed high levels of transformational leadership but interviews revealed other factors preventing them from maximising their effectiveness all of which correlate with findings here. These included organisational politics; culture and the tradition of nursing with nurse leaders seen by followers as displaying laissez faire leadership; and an inconsistency in nurse leadership. Authors argue that this last issue was caused by the politicised environment which prevents them using their own abilities and affects their confidence. Although this study originally aimed to study nurse leaders, respondents frequently referred to doctors and managers as affecting them. Kan and Parry's study also highlights the importance of using qualitative methods in addition to the MLQ which did not highlight issues subsequently picked up via the interviews.

Within this thesis, however, the most significant factor cited as influencing context, culture and leadership was the role of chief executive and top management team (TMT). They set and influence values, beliefs, priorities and aims, the context and environment and shape the long term culture of the organisation. Styles and behaviours demonstrated by the CEO and TMT were considered particularly important as this indicated what was acceptable or not. Charismatic and transformational leadership characteristics and behaviours were thought paramount at this level supported by Zhu, Chew and Spangler (2005) who suggested that

CEO's who were more transformational were more likely to adopt empowering and human approaches and practices such as training and staff development. This is also supported by Dickson, Smith, Grojean and Ehrhart (2001) who showed these roles affect the appropriateness of certain behaviours within the organisation and beliefs that may or may not be consistent with current orthodoxy. He uses the term 'climate surrounding ethics' since he feels the latter term may imply congruence with more generally accepted ethical standards. In his and others views organisational leaders drive the climate surrounding ethics. Organisations wishing to change existing values need to work through leaders to achieve change. This links well with findings in this study revealing links between values, culture and behaviour.

To authors such as Schein (1985) transformational leaders acquire their capabilities by manipulating culture and since Bass (1985), Kotter and Heskett (1992) have argued that the outcomes of transformational leadership are evidenced in the changed culture and performance of staff. This study would suggest these thoughts and proposals are rather more difficult either to accomplish in the health service or to evidence. As already indicated in this thesis; firstly respondents felt the overall impact of leaders on organisational culture (not context) was driven mainly from senior management; secondly that this affected them more than their ability to influence or change it; and thirdly whether they were able to do this was dependent both on local context and on the approach of the CEO and TMT.

The view that senior leaders do play a distinct role in influencing groups and individuals is supported by conceptual and empirical evidence (O' Reilly *et al*. 2010, Bass 2003, Degeling and Carr 2004, Argiris 1990). However, in the health service, little is known about the relationship between senior leader behaviour and effects on individuals, teams and organisations or about the circumstances under which leaders are able to affect performance. How they do this is even less clear although links have been made with increased performance. A review conducted

by Tsui *et al*. (2006) highlights that different philosophical stances have different takes on the relationship between CEO leader behaviour and organisational culture. The studies reviewed emphasise leaders' roles in shaping culture and show links with charismatic leadership particularly shaping the values of organisations. Several authors rightly stress the importance of functionalism. The functionalist view is cited as dominating organisational cultural literature indicating links and behaviours associated with charismatic leadership such as, having confidence, vision, having strong assumptions about organisations and society. It considers leadership to be the main founder of organisational culture as opposed to the anthropological view which considers that it emerges from collective social interaction of people. Functionalist approaches are considered to result in a close link between CEO leader behaviour and the creation of shared strong cultural values. Their actions and behaviours contribute to the substance of an organisation's culture. This thesis would appear to indicate that respondents consider that within health boards culture is set predominantly by the CEO, senior leaders and managers.

Carmeli (2008), Carmeli and Schaubroeck (2006), Carmeli and Halevi (2009) discuss the top team's role in creating an adaptive environment emphasising the influence of top team dynamics and the importance of top teams' characteristics. Reference is made to behavioural integration and importance of leadership qualities and characteristics that begin at the top. Behavioural integration is achieved via collaborative rather than autocratic styles of leadership which the author considers to depend on the CEO. The articles also discuss the importance of the top team as opposed to one individual. Whilst it could be agreed that leadership is about collective effort, in this study it appears to be dependent on the leadership style of the CEO. Literature within the health sector appears absent in either disputing or supporting these views.

Despite the importance of the top team O' Reilly *et al.* (2010) explore how senior leaders ensure group and organisational members implement their decisions. The study focuses on how consistency of leadership effectiveness across hierarchical levels influences the implementation of an initiative in a larger healthcare system. The study found that it was only when leaders' effectiveness at different levels was considered as a whole that significant performance improvements occurred. O' Reilly *et al*. feel that should messages lack clarity and consistency among leaders at different levels they may reduce staff's ability to understand the importance of strategic decisions and initiatives. This is also supported in the literature (Cha and Edmondson 2006) and to a certain extent was referred to in this study.

O' Reilly *et al.*'s (2010) study takes place in the US with three hundred and thirteen physicians with a hypothesis that if the CEO supports a strategy, the stronger the likelihood that it will be implemented and that it is the collective support by leaders at different levels that is important. The study's results are important for a number of reasons. Results suggest that it is not the effectiveness of a leader in isolation that affects organisational culture and performance but the alignment of leadership across hierarchical levels that is associated with the successful implementation of change. He claims that had they only studied the CEO role they would have concluded that the CEO had no effect on performance. It was by examining the combined effects of leadership and employee support that the effects on performance became apparent. In O' Reilly *et al*.'s study the CEO remained in post throughout data collection yet there was wide variation in how effective or ineffective he was seen to be. These perceptual variations were associated with variations in objective organisational outcomes suggesting that how employees see and interpret the behaviour of leaders can be an important moderator of performance. Where followers believed in the new strategy and saw their leaders effectively supporting it, overall patient satisfaction improved. When there was disagreement about the strategy or leaders were seen as ineffective performance was lower. The same objective actions by leaders resulted in different subjective

interpretations and substantive variations in performance. Leadership in this context is however different from the NHS where roles and formal lines of authority differ. Challenges and constraints have similarities but specific differences which therefore reduces the extent to which any generalisations can be made. The study considered formal leadership roles only and did not explore characteristics styles or behaviours considered important by employees. However the study does suggest that it may be the aggregate effects of leaders at different levels that are important. The CEO may act as a cipher interacting and affecting a 'joint policy'. In this thesis respondents referred to this role also emphasised by other writers (Hambrick, Cho and Chen 1996).

In drawing these strands together then considerable literature is now available linking organisational culture, performance, job satisfaction, commitment and wellbeing. Although not directly relevant some interesting associations can be made with other important issues in this study. Park and Kim (2009) link consensual cultures (defined by teamwork and human relational aspects) as strongly associated with job satisfaction supported by Yiing and Ahmad (2008) and Mallak *et al*. (2003). These studies show significant links between leadership behaviour and organisational commitment, job satisfaction and performance, and that organisational culture and environment can play a moderating role in this relationship. What is of particular interest is that the factors listed as important in these studies directly correlate with those found in this study and other literature: role modelling, feedback on performance, communication of what is important, and links with values of the organisation.

Given what is valued, how leadership is perceived in the health service, and views about context and culture, the next and final section exploring findings discusses the relevance and application of current leadership models and theory.

Linking leadership theory and models

The findings of this thesis suggest that there are three models of leadership which are directly applicable to the NHS; charismatic leadership theory (as a separate but also as one of the four components of transformational leadership); transformational leadership and congruent leadership although a number of other components also emerge as important: emotional intelligence, ethical and relational leadership and adaptive leadership theory. These will now be discussed in some detail in terms of their relevance and future application when considering leadership in the NHS.

Charismatic leadership

Definitions of charismatic leadership emphasise leaders' ability to influence followers to rise above self interests through presenting strong idealised values and goals which are then adopted by followers. Charismatic leadership like transformational leadership is felt to be effective in organisational environments characterised by a high degree of change or by great opportunity for change in stable environments such as the NHS. Leadership is centred on helping organisations and people adapt and adjust to changing environments and opportunities. Characteristics specifically associated with these modes are ones that are required for successful achievement. These influence the assumptions and values needed to change behaviours such as: good interpersonal skills, trust, collaboration, engagement, listening and valuing people. This perspective also links with Schein (1985) who emphasises that the main function of leadership is to provide direction, contain peoples' anxieties, frame peoples' interpretations and influence their values and assumptions. This is also why it provides an important part of transformational leadership (idealised influence) and why transformational behaviours are considered more effective as they are about creating and changing organisational culture as opposed to stability and status quo.

In considering its links to context and culture Shamir and Howell (1999) take the view that charismatic leadership principles and processes potentially apply across a wide variety of situations. However there are situations in which they apply more than others. So the emergence and perceived effectiveness of leadership may be facilitated by some contexts and inhibited by others. In adopting this view they follow earlier contingency theories of leadership (Fielder 1967, Hersey and Blanchard 1977, Vroom and Yetton 1973) which attempted to specify the conditions under which other dimensions or leadership styles are related to leadership effectiveness. However unlike these earlier theories which focused on characteristics of small groups this considers broader organisational conditions. Shamir and Howell's paper theoretically specifies conditions under which charismatic leadership is more likely to emerge and to be effective and importance is placed on linking organisations leadership to the organisational setting in which it is embedded. This takes the view supported in this study that large organisations play an important role in determining and moderating leadership processes and therefore a leadership theory should incorporate macro - level considerations and conditions. This view is agreed by other authors (Hunt 1991, Tosi 1991).

Relationships can also be made to perspectives of adaptive and non adaptive cultures, a distinction suggested by Kotter and Heskett (1992). Adaptive cultures are characterised by common values and ways of behaving that emphasise innovation, risk taking, integrity, teamwork and enthusiasm. Non adaptive cultures stress order and efficiency and they are averse to change innovation and risk taking. An adaptive culture will allow more for the development of charismatic / transformational leadership for reasons similar to those that rely on a clan mode of culture. They encourage intellectual stimulation and innovation, depend on members' commitment and increased levels of trust. So clan, adaptive cultures and organisations make situations more receptive to charismatic and transformational leadership and make the task of reinforcing organisational values and identities easier. These are theories which clearly resonate with what

respondents emphasised in this thesis although in describing reality situations are clearly considered non adaptive.

Recent theories of charismatic leadership in organisations (Bass 1985, Conger and Kanungo 1988, House 1977, Bass and Avolio (1993) share the assumption that such leadership can be found at all levels of organisations, from top level leaders to lower level supervisors. Evidence in this study suggests that this component of transformational leadership is particularly important at senior and middle management levels where it is considered essential to achieve change, engagement and instil values. However findings also point to leadership and leaders' attributes needing to be different at different levels within organisations reflecting different roles, pressures, environments and circumstances. For example lower level leaders are said to be much more influenced by their immediate managers and environmental context than by more senior leaders.

Transformational leadership

All four components of transformational leadership in this thesis were evident in delineating characteristics and behaviours valued by participants: idealised influence or charisma (values, meaning making), inspiration, intellectual stimulation (decision making, risk taking), individualised consideration (relationships, engagement, development, learning). However idealised influence/charisma and individualised consideration stood out as being particularly important. A number of recent studies also emphasise these two components as particularly vital because of their links with values, characteristics and styles. Specifically emphasised as important is the recognition of individual differences and needs and engaging relationships. Theorists consider transformational leaders to be more internally directed; transactional more externally directed (Howell and Avolio 1993). Transactional leaders work within the rules of organisational culture while the transformational leader changes rules or culture based on his or her own vision. In these descriptions both styles of leadership also include context but in different

ways and with different methods. Inspirational leadership has the ability to deliver messages ideas and words in ways that grab followers attention, and relate leaders' messages to what followers believe is important. To do this requires individualised consideration and attention to the needs of the group or individual so that the leader can utilise those needs to achieve the goal or vision. As Avolio says, it is difficult to imagine a leader being inspirational who has no sense of what his followers require, what they value or what they understand. Authors have noted in earlier studies (Avolio and Bass 1988, Bass and Avolio 1990) that the more transformational the leader found at higher organisational level the more it is expected to be seen at lower levels. This leads us to ask whether low level leaders model themselves on senior leaders, or whether low level leaders' roles are affected by the style of senior leaders in the organisation.

How these things are studied always differ according to context but there do seem to be some consistent themes. Individualised consideration was considered a very important part of transformational leadership in this thesis as it is the component linked to how leaders listen and interpret employees' needs and then adjust their behaviour accordingly (Cummings *et al*. 2008). This also reflects the need for high emotional intelligence. This study suggests that this can take place at three levels, individual, group, and organisational and that leaders adjust their behaviour and interactions to fit with 'adaptive style' theory. Individualised consideration also allows leaders to influence people to forgo their self interests and to have a greater concern for colleagues and the organisation. Much depends on the relationship and interaction between the leader and follower. Authors say that in order to do this, leaders must understand 'self interests' and the organisational context. Thus far therefore links can be made between charismatic leadership, transformational leadership and context. In addition to individual impacts therefore, transformational leadership may also influence follower performance by transforming the general climate of organisations, although this has received much less attention in terms of research. Studies exploring specific links are limited but

two have some relevance (Liao and Chuang 2007, Koene, Vogelaar and Soeters 2002).

Liao and Chuang (2007) claim to show that transformational leadership may be capable of transforming the environment to form a positive climate. Although results did not show a significant relationship between climate and individual performance they suggest that employee performance may be improved when transformational leadership behaviours are accompanied by the development of a positive work climate. Authors claim climate provides a strategic focus for transformational leadership behaviours enabling transformational leaders to be more effective in encouraging staff in achieving high quality services. Results also corroborate Schneider, Ehrhart, Mayer and Saltz (2005) providing empirical support to the notion that strategically focused leadership behaviours have more effect than generic leader behaviours on employee attitudes and behaviours in achieving particular strategic objectives. Questions need to be asked about the extent to which results can be considered generalisable, although they do show consistency with others and therefore may not be sample specific. Results suggest that transformational leaders may play an important role in building long term service relationships by transforming both the attitudes of front line employees and work climate.

Transformational and charismatic leadership link the visionary aspects of leadership and the emotional involvement of employees within the organisation. Such leaders attain better performance because they seem able to make people more aware and responsible in their roles. It suggests that the most important role for transformational leaders with vision is to focus on collective goals and give constant support and encouragement to their staff. Different emphasis is needed of course at different levels within an organisation. The more senior levels require a charismatic component whereas at the lower levels more importance is attached to individual components. It means that leaders may need a different emphasis on

their leadership behaviours to obtain desired outcomes at individual or group level. This fits with adaptive leadership and Koene, Vogelaar and Soeters (2002), Alimo-Metcalfe and Alban-Metcalfe (2005), Alimo-Metcalfe *et al* 2008) and Shamir's (1995) findings, and the need, as in the health service for leaders to undertake both at the same time.

Congruent leadership

Congruent leadership has been introduced as a new leadership concept by Stanley (2006) as the most appropriate leadership theory to support an understanding of clinical leadership, based on the notion that historic theories of leadership do not fit with clinical leadership in the NHS. Stanley highlights that historically, concepts of leadership have been related to nurse management positions which have been based on change management and vision, and therefore to leadership theories that support these such as transformational. He feels these are not necessarily transferable when seeking to understand clinical leadership positions and points out the assumption then that leaders' must have a vision, influence and power to see the vision through, a characteristic not valued in all recent studies. Congruent leaders (this applies to all clinical nurse leaders) are followed as there is a match between their values, beliefs and their actions. Within Stanley's studies despite the important differences proposed in terms of values, no differences in characteristics or behaviours were found in clinical leadership as opposed to general leadership other than clinical competence and clinical knowledge, also referred to as 'having credibility'. Although important, other components of transformational leadership particularly those associated with idealised influence and consideration were considered just as important and can be applied to people without a clinical background. Possibly the importance of these in practice relates to the actual aims and objectives of roles and expectations of individual leaders. However what is paramount is the leader's ability to listen and engage with staff. Transformational leadership is strongly associated with organising and building relationships and is seen as being connected to a process of attending to the needs of followers. The

interaction of each raises the motivation and energy of the other resulting in a new vision empowering others, which also impacts on culture (Day *et al*. 2000:15). Because of this interaction and style, transformational leadership is relevant within the health service, particularly nursing. What is particularly evident in this study and other NHS studies is that what is valued is based on values and beliefs. Drivers and motivations in nurses appear to differ, and are based on patient care as they are guided by their passion for care, and are concerned with empowering and building relationships with others. This is why the achievement of targets and more managerial based approaches cause tension. Edmondstone (2008) points to the belief by politicians that targets motivate staff but as has been pointed out they motivate people to hit the target, as opposed to motivating people to improve and do a better job – sometimes called 'hitting the target but missing the point'.

Other related components / concepts

In addition to charismatic, transformational and congruent leadership theories respondents stressed the importance and relevance of a number of other elements which in the general leadership literature have often been considered separately. These included; emotional intelligence, ethical leadership, relational aspects and adaptive leadership theories.

Within the literature emotional intelligence is characterised by self awareness, supervisory skills, positive empowerment processes, resilience, innovation and change. Akerjordet and Severinsson (2008) reviewed literature on the theoretical and empirical basis of emotional intelligence and its links to nurse leadership. The review indicated emotional intelligence was associated with positive empowerment processes and positive organisational outcomes. Reference is made to the benefits and connections with transformational leadership particularly self awareness and empathy (Yoder 2005), regarded in this thesis as particularly important. Authors conclude that the most effective leaders are those with high emotional intelligence characterised by four leadership styles; vision, coaching, affiliative and democratic.

They consider that emotional intelligence and nurse leadership reflect a different leadership style which emphasises personal reflection, wellbeing, strong relationships, pursuit of common goals as well as the need for co-operation and a team - based working climate (Akerjordet and Severinsson 2008:569). It is proposed that wellbeing and then performance is influenced by our ability to regulate emotions and establish desires that are congruent with core values or personal convictions and that leaders with increased emotional intelligence manage their emotions in more functional ways. This helps followers work and communicate more effectively and is more likely to use supportive behaviours and be more sensitive to followers' needs and feelings. Emotionally intelligent nurse leaders are able to identify their own values, morals beliefs and emotions leading to a deeper understanding of 'self reflecting authenticity' (Goleman, Boyatzis and McKee 2002).

Over the last few years there has been considerable interest in the development and prominence of ethical leadership thought important because of the impact leaders may have on the conduct of others and the organisation. But despite this importance empirically based knowledge is limited and little is known about the personal characteristics of ethical leaders (De Hoogh and Den Hartog 2008). Links have been made to authentic leadership, integrity, honesty, trustworthiness and role modelling evident in behaviours. Through role modelling ethical leaders promote altruistic behaviour among employees and as a result followers are thought to become more focused on co-operation and more committed to the organisation. Through ethical behaviour leaders earn the confidence and loyalty of their followers. Where the leader's integrity is in doubt leaders are unlikely to influence followers to achieve organisational goals (Kanurgo 2001). In some cases empirical evidence is lacking but related research does suggest positive relationships (De Hoogh and Den Hartog 2008:300). For example research on perceptions of leadership shows that honesty and integrity are associated with perceived leader effectiveness (Alimo-Metcalfe *et al*. 2008).

In relation to nursing the importance of ethical leadership has been found a key issue in one study by nurse managers and that the leadership model chosen corresponded with the ethics of the profession (Lindholm, Sivberg and Uden 2000). Despite the lack of empirical evidence it is apparent in all recent studies of leadership within the NHS that characteristics associated with values and ethics are particularly important to staff. Context and reasons for decisions also appear critical and are particularly important to leaders because of their frequent need to justify these decisions to others. In this investigation it was important that staff saw a link between reasons for decisions and their implementation and often leaders trustworthiness appeared to be judged by their ability to act consistently with their stated intentions. Connections can be made here again to values, context and beliefs and to what is referred to in the literature as behavioural reasoning theory (Westaby, Probst and Lee 2010). This hypothesises states that leaders' reasons do not exist in isolation but can be explained by their cognitive processes such as value and belief models. The evidence based reasoning process suggests that the more that leaders base their reasons in relevant objective evidence and empirical research the greater the decisions quality and accuracy.

Likewise aspects of relational leadership theory are extremely relevant and are built on the notion that leadership is about collective action, establishing meaning which is about paying attention to relationships between individuals recognising that they are part of wider systems in organisations and communities shaped by relational approaches (Uhl-Bein 2006). In this perspective, leaders, staff and their relations do not exist as separate from the leadership process itself. This is line with Alimo-Metcalfe *et al.* (2008), Heifetz (1998), this study's findings and contextual requirements of organisations and their leaders. In the literature this has also been referred to as integrated leadership (Ospina and Foldy 2010). Markham, Yammarino, Murry and Palanski (2010) discuss the importance of what they refer to as quality exchange relationships between a leader and employee engendering trust, respect loyalty, liking and support.

In summary, this study suggests that there are models of leadership particularly relevant to the NHS but that how these apply and are applied in practice differ both according to role and hierarchical level within the organisation. The characteristics associated with charismatic leadership appear more important at chief executive and top management team level in setting values, beliefs and organisational context and culture. The characteristics and behaviours associated with transformational leadership are also important as is the need to understand the role and relevance of congruent leadership theory to clinicians. The role of middle manager appears particularly complex requiring a combination of characteristics and behaviours linked to charismatic, transformational and congruent leadership models and theories. Clinical leadership roles and first line leader/manager roles appear predominantly associated with congruent and transformational leadership with less emphasis on the characteristics of charismatic leadership in relation to behaviours but not in importance of the underlying principals which are regarded as just as relevant and important.

Behaviours and models of leadership will vary according to individual organisations, culture, chief executive and top management team. A clear division is apparent between leadership and management functions in the NHS which require different characteristics and behaviours. Drawing on some similarities from Stanley's work this thesis lends support for a new leadership paradigm which draws on these elements, characteristics and behaviours valued by staff and clinicians. This is also based on the assumption that previous models do not take into account the key role professional values play in how clinicians view leadership in the health service, and how this then influences their actions and perceptions of their leader's behaviour.

Discussion now returns to the three research aims of this study which were to:

- Explore how leadership and leadership behaviours within the NHS and particularly nursing function in practice.
- Explore what part the environment, context, organisational culture and the dynamics of NHS organisations play in how these behaviours and roles develop and function.
- Explore how these might help us understand the issues facing nurses, nurse managers and health boards in modernising and implementing new leadership roles.

These aims are now used to frame concluding remarks, to set out how these relate to theoretical models discussed and to guide recommendations made in relation to policy and practice

Concluding remarks

This study indicates that staff value a specific set of leadership characteristics, styles and behaviours and considers that the context and culture of individual health boards play a considerable role in influencing how these take shape in practice.

Whatever characteristics, styles, behaviours or models of leadership are appropriate for the NHS and nursing they cannot be considered in isolation from complexities of practice and context. Within nursing these complexities predominantly stem from the creation of new and hybrid leadership roles (for example nurse consultant), but also general, clinical management, or middle management roles. What appears to cause complications is that these roles, besides having different aims and objectives, have different drivers and require different leadership styles and behaviours. As discussed within the literature this does not appear to be a new issue. However the complexities associated with these roles appear to have increased, possibly because of the increase in transactional agendas from the

government or possibly because of the current amount of dual/hybrid roles, both of which were cited as reasons in this study. Investigations showed that within health boards, tensions were evident across the organisation and particularly evident at middle manager level where roles are expected to be transactional and transformational; dealing with senior, middle and first line managers and staff with multiple obligations. This appears to be a particular issue for nurses who occupy many of these roles.

It appears that often the way we operationalise leadership assumes that holding a management position corresponds to leadership. However respondents clearly articulated these as two separate but complementary disciplines with different components. If this is the case the NHS needs to develop consistent expectations across roles, styles and behaviours. Some authors claim it is not the difference between leadership and management that is important but how the person embodies and enacts the skills (McCartney and Campbell 2006) therefore presenting a model that has a combination of skills. Within the literature however there appears to be little understanding of how clinical managers interact and whether styles of hybrids are different from those of general managers.

The main issue associated with this conflict not only arises from the difference in styles and behaviours but from a conflict between organisational and professional values and expectations. This is also supported by many recent studies which illustrate the tension and difficulties of a role with both clinical and managerial elements. Interviews for this study revealed organisational and professional conflicts; unease experienced by professionals between the requirements of their employer and those of their vocation; differences between professional values and organisational management objectives; and tensions in dual roles within an organisational context and culture that wants both change and the achievement of business targets. This was also influenced by the culture and environment set by the chief executive and top management team where emphasis on what is

important such as innovation and change had to be balanced against the budget. Tensions were seen here in a number of ways including what leaders described as differences in expectations between their day to day role and what they wanted to achieve.

Stanley (2006b, 2008) describes an increasing gulf between clinicians' expectations and responsibilities and senior leaders - managers further removed from clinical care. Although this issue was not particularly evident in this study, tensions and values were exacerbated by the fact that respondents considered they spent more time on managerial and organisational aspects rather than on clinical aspects.

Traditionally the NHS has associated leadership with vision and achieving change. This thesis and other recent studies challenge this view indicating that although these are important components of organisational objectives, what staff in the NHS value in leaders and leadership are the relational aspects of leadership. They place particular importance on how leaders function within the organisation and how we enable people to do a good job. This view has important implications for the traditional NHS response to the need to achieve change, which is to 'increase leadership'. There is resentment at a concentration on individuals and individual new roles as opposed to concentrating on how current leaders function within current organisations and contexts. Leadership is undoubtedly a complex and difficult issue which, as this thesis highlights, not everyone is good at. Individuals may be able to learn particular styles and characteristics but whether they are able to translate this into practice and affect others is considered an entirely different thing. Leadership is about inspiring and working with others, and whatever model you apply this is primarily about relationships with people and associated interpersonal skills. We appear to think in the public sector, and particularly the NHS, that all employees are 'good with people', have good interpersonal skills and therefore make good leaders. As seen in this thesis, this is not what staff feel. Consideration should be given to this in the NHS if it wants to maximise its

performance, change efficiency and improve the wellbeing of its workforce in the future.

The next section of this chapter will discuss this study's contributions, implications for policy and practice and then consider limitations and reflections.

Study contributions

This study produced some significant results. Firstly, it reveals leadership to be made up of two distinct elements: one which relates to individuals and one which relates to how these individuals function in organisations which involves their relationship with organisational context and culture. Secondly, it supports recent studies conducted in the NHS which indicate that staff value a clear set of characteristics, styles and behaviours which are not related to vision and change but which centre on peoples' character, values, integrity and honesty and how they engage and relate to people and situations. Thirdly, in order to provide leadership and function within the NHS as a leader, another set of skills is required which involve management and interaction not only with staff but within organisational context and culture. Fourthly, within nursing, a number of particular complexities make this particularly challenging.

The study adds to knowledge on leadership theory, particularly charismatic and transformational leadership. It supports the importance of two particular elements within the NHS, idealised influence and consideration, and the application of these in practice. The role of values has largely received little attention within the health service and this study lends support to Stanley's work suggesting they play a key role in leadership, influencing followers' perceptions of leaders and leadership, facilitating motivation and behaviour. Findings suggest that when a follower perceives a transformational leader who is considerate, respectful, engaging and credible this serves as a basis for effective relations and possibly increased

performance and job satisfaction. The applicability and relevance of other leadership theories such as models of congruent leadership and those emphasising the importance of relationships also contributes to the now growing, but still very limited, body of knowledge on leadership in the NHS and highlights the lack of current understanding in relation to some of these areas. Findings also suggest that leadership behaviours and theories apply differently at different levels within organisations.

Additionally the study emphasises that leaders and leadership cannot be studied as isolated factors or characteristics but must be interpreted in the actual and specific context in which they occur, making each situation and organisation potentially different in application and understanding of the terms. It clearly sets some challenges for the health service in relation to policy and practice, particularly the need to focus on leadership in organisations and how leaders function and operate in complex and challenging environments. This study suggests that, in addition to refining appropriate leadership characteristics relevant to the NHS, consideration needs to be given to acquiring knowledge of organisations in order to achieve effective leaders and leadership.

There are implications for recently emerging work on clinical leadership and for government proposals for increasing the number of clinical leaders within the NHS, whilst at the same time increasing efficiency and cost saving. In examining the roles of leaders in practice this study expands the network of constructs previously reported as important and also those which produce conflict and tension.

The thesis now considers recommendations for policy and practice. For clarity recommendations are set out in relation to the three research aims of the study.

Implications for policy and practice

Research aim one: *To explore how leadership and leadership behaviours within the NHS and particularly nursing function in practice*

Policy

- The Government needs to utilise leadership theories which are relevant to the NHS. These are Charismatic, Transformational and Congruent models of leadership.
- Leadership development and quality frameworks must focus on these models of leadership. These need to encompass the qualities, characteristics, styles and behaviours needed to be a leader in the NHS; and how these should be applied in practice and directed towards how leaders function in organisations.
- Training for nurses, doctors, and other professionals needs to include increased emphasis on the importance of these qualities, on being a leader and working in organisations.
- Nurturing and developing leadership in the health service is not linked to performance of the organisation and core functioning. The NHS needs to assess its leaders and leadership in organisations by the development of appropriate outcome measures as opposed to the achievement of targets which cause conflict and tension and do not enable staff to focus on enhancing the quality of patient care.
- Leadership policy frameworks for the NHS need to be relevant to roles required and based on appropriate knowledge and research of what is needed to function and lead organisations at each different level such as: chief executive, top management team, middle management, clinical leadership roles, and first line management. Recent research indicates that the skills required for these differ.
- In response to recent challenges and pressures, discussions and policy in the NHS has centred on increasing leadership and the number of leaders from clinical backgrounds (Darzi 2009). This creates additional tensions and

complexities. Current challenges should be addressed by supporting existing leaders and how they function within organisations as opposed to the creation of new leadership roles.

Practice

- Clinical staff value a clear set of leadership characteristics, styles and behaviours which differ from traditional models of leadership. These centre on peoples character, values, integrity and honesty, and how they engage and relate to people and situations. The NHS needs to listen to its staff and recruit leaders with these qualities who are able to demonstrate these in practice.
- The NHS must move away from competency based models of leadership and move instead towards models of leadership that take into account the relationship and role of environment, context and culture.
- Leadership models which are pertinent to the NHS are: Charismatic Leadership which concerns values, goals, collaboration and trust and is particularly relevant to creating positive culture and context; Transformational Leadership particularly idealised influence concerning values, meaning making, risk taking and idealised consideration which emphasises relationships, engaging behaviours and development and learning, and Congruent leadership relevant particularly to clinicians and emphasises values, meaning, interpersonal skills and relationships..
- There are two critical aspects to leadership; what is done and how it is done.

  The NHS needs to review its key objectives, consider their importance and ensure its leaders reflect these in corresponding approaches and behaviours.
- Leadership and the leadership attributes and behaviours required and valued differ at hierarchical levels within organisations. These reflect the differing roles, pressures, environment and circumstances. Charismatic leadership behaviours are more important at a senior level and more individual and relational components at middle and lower levels. The NHS must review the

skills and qualities required within each post and give consideration to the level and role the post occupies within the organisation.

***Research aim two**: To explore what part the environment, context, organisational culture and the dynamics of NHS organisations play in how these behaviours and roles develop and function.*

Policy

- The role of the chief executive and TMT is critical. The government and chief executives must assess leadership capability and behaviours in recruiting and in the ongoing assessment procedures of both boards and individuals.
- These roles are particularly influential in setting the culture and tone of organisations which are related to charismatic models and qualities of leadership emphasising engagement, trust, collaboration and integrity – particularly important in creating enthusiasm and trust for innovation and change. These qualities need to be included in all recruitment procedures for this level of staff.
- The culture and context of health boards matter and influence how leadership and leaders roles take shape and function. Considerable evidence now exists which links these factors to efficiency, effectiveness and well being within the NHS. Appropriate recruitment of chief executives and TMTs is therefore critical.
- Governments need to understand the relationship between these qualities and the differences required in the skills at each level of the organisation in achieving outcomes at both individual and group level.

Practice

- Chief executives and the TMT need to be explicit about their values and the values of their organisation ensuring a match between their values, their actions and behaviours within the organisation.

- Clinicians value leadership which centres on a clinical care model as opposed to a business, technical or transactional one. Chief executives and senior leaders need to consider this in relation to change and performance.
- Clinicians follow people who demonstrate their values in practice and who have a match between their values, beliefs and actions. They are unlikely to follow those that do not.

***Research aim three**: To explore how these might help us understand the issues facing nurses, nurse managers and health boards in modernising and implementing new leadership roles.*

Policy

- Organisations need to embrace a model of leadership that emphasises excellence and teamwork but ensures that leaders are selected on the basis of character, values and attitude as well as technique, expertise and skills.
- Developing leadership in the NHS and nursing has traditionally concentrated on leaders as opposed to leadership or leaders' roles in organisations. Both are needed and both are equally important.
- The NHS has a number of different leadership and management roles. Consideration needs to be given to how these roles integrate and work together and to where additional capacity and resource should be targeted: leadership, clinical leadership, management, or roles that encompass a combination.
- Many relevant studies on leaders and leadership in the NHS appear in the grey literature, are difficult to access and therefore to disseminate and utilise in practice. Greater consideration needs to be given as to how these are publicised to the wider health service.
- The terms leader and leadership are different. Thought needs to be given to their use and application and these differences need to be reflected in training, development and wider organisational understanding.

- Values influence clinicians' perceptions of leadership and leaders' facilitating motivation and behaviour and possibly performance and job satisfaction. Consideration must be given to this when considering any change or development in the NHS.

Practice

- In responding to the challenges of today's NHS clinicians feel that rather than increase leadership and introduce new leadership roles, investment should be given to supporting existing leaders and leadership roles. This must include equipping and enabling them to function within organisations.
- We need to nurture leaders by promoting learning from work experience, positive role models, shadowing, mentoring, coaching and by exploring ways that leadership and leadership behaviours can be learnt 'on the job'.
- We must recruit leaders and nurse leaders who have appropriate leadership skills which are valued by staff. These centre on transformational and engaging aspects of leadership as opposed to transactional or technical expertise.
- Staff clearly value characteristics and behaviours which do not relate to vision and change but which relate to more human and relational aspects of leadership. This must be given priority in recruiting leaders in the NHS.
- Attention must be given to the factors staff consider support and constrain leadership in practice. These factors must be addressed and either supported or confronted by senior leaders in organisations.
- Leadership is a complex and difficult issue. Not everyone makes a good leader. The NHS must acknowledge this and review its approach and criteria for recruitment into leadership posts.
- Clinicians feel health care is dominated by a business model which centres on the achievement of targets. What nurses emphasise as having to be done differs from what they feel should be done. The NHS needs to review priorities and the time clinicians spend on what they consider to be managerial and administrative tasks and activities as opposed to patient care.

- Leadership and management are different requiring different styles and behaviours. Complexity and conflict arises particularly within clinical roles and services where these two separate functions are combined in one role. This is exacerbated when clinicians feel they spend more time on managerial activities versus clinical ones. Organisations need to review the roles they require together with their key functions, i.e. are they clinical, managerial, leadership roles, or all three?
- For clinicians, having a sense of purpose provides worthwhile meaning to their roles and is therefore particularly important. Leaders and managers need to ensure staff feel valued and listened to and ensure their time is well spent on activities that promote staff and patient care.
- Particular attention should be paid to how leaders respond and behave in organisations, their attitudes and mindsets.
- Leaders must be judged as much on their behaviour as on their performance. Leadership and leaders behaviours within organisations must be assessed and monitored by the staff they lead and work with and by the alignment and review of measures such as absenteeism, wellbeing, directorate or group performance.

Directions for further research

The study provides several significant implications for future research and theory building. Firstly, considerably more is now known about leadership in relation to individuals and the last three studies in the NHS have provided fairly consistent results and evidence that leadership is not just about skills but about characteristics, behaviours and how these are applied. However considering the importance of leadership very little is known about leaders' roles within the wider NHS organisation. This study and others point to the importance of adaptive, charismatic and transformational leadership behaviours and emotional intelligence. However little detail is known regarding what skills are required, where, and in

relation to specific culture and climate. Despite one or two studies (including this thesis) and theoretical links, there is still limited empirical support in the NHS.

Secondly, considering the important role of the chief executive and top management team discussed here little if any study has been undertaken. These results should be explored in further research in an attempt to illustrate what factors are important and how these relate to other leaders in the organisation.

Thirdly, recent studies have started to consider the effects of leaders on the environment, context and on job satisfaction and performance but this is still very limited in the NHS, as is the attention given to the role of context on leaders and leadership. Fourthly therefore, another important avenue for further research is the need to further explore relationships between context, culture and leadership in order to understand its effects on roles, functions and performance.

This study found that clinical leadership is considered important particularly indicating certain factors and values which have received little attention in terms of research. Future research needs to investigate the link between leader activities and values and particularly how it relates to clinical leadership which has important implications for how leaders function and make decisions. Another potential avenue for future research is to consider the development of a new model of leadership for the NHS incorporating what we now know to be valued and effective. What leadership means to nurses and or clinicians appears to vary from others and is worth further qualitative study to add greater depth to the conceptualisation of leadership.

Differences in leadership and management were clearly evident in this study. The significance of these differences in practice is that the tensions and conflicts between clinical values and organisational objectives places nurses with both leadership and management responsibilities in positions which affect their ability to

lead and manage as effectively as they might. Additional work should explore exactly what is required and where, and focus on whether combining leadership and management functions in single posts is or is not efficient, effective and detrimental in nursing. Given the emphasis on leadership in the NHS and nursing, understanding the factors that contribute to enhancing nurse leadership can help organisations create strategies to develop leaders and leadership. However what was suggested in this study is that not everyone makes a good leader and future research should look closely at developing robust theory and research on interventions to develop and promote the right leaders and leadership in nursing. Methodologically understanding the nature of leadership in the NHS is undoubtedly complicated and may necessitate study from a number of perspectives and methods.

Study limitations

Although study design offers benefits to the research process used and generates more confidence in the findings it has several limitations. Firstly, the sample for this study was purposefully selected from a specific set of health professionals, at a particular point in time, within the NHS in Scotland. Recognition therefore needs to be given to this when interpreting findings. Secondly, the sample consisted of fairly experienced senior leaders or managers in specialised roles. Although this was purposefully done to ensure a depth of knowledge and draw on respondents experience it may present a different picture from nurses working entirely at the coal face. This may have been exacerbated by the use of theoretical / purposeful sampling. By asking senior nurses in phase two to nominate participants for phase three this limited the researchers control in ensuring the inclusion of non specialist nurses. This limitation has to be balanced against the in-depth knowledge gathered from those who did participate which may not have been the case with more junior members of staff, particularly in relation to their exposure to the more political and wider contextual issues within the organisation which is what this study was interested in exploring. Phase two participants were fully briefed on their choice of

nominating who they felt appropriate and it was interesting therefore who was nominated. This did not include charge nurses in either health board area but posts where leadership was felt to have increased and noticeable outcomes achieved. This may indicate how leadership is defined in the NHS but is perhaps more likely to have been a pragmatic decision based on people the respondents were in day to day contact with. Emphasis for the study was put on staff in leadership roles which may have been interpreted as concerning specific posts as opposed to people that display leadership although this was explained.

Thirdly, generalisations in the findings may be limited as the sample was drawn from only two organisations. Although this allowed practical and manageable study some may question the generalisability of findings reflecting the tensions in qualitative research in seeking breadth in terms of population and depth in terms of quality of data. Although a growing body of research in transformational leadership has reported consistent results across settings and cultures it would be enormously valuable to replicate the current study across a larger number of health boards to test consistency of its findings. Including different geographical areas such as those with remote and rural communities could have raised differences in access to leaders and leadership and large geographical areas would perhaps necessitate different working practices. Considering the inclusion of additional health boards therefore could add to validating findings. However, after twenty four/twenty five interviews little significantly new information appeared to be gained and questions therefore could be asked about other benefits of including further health boards. On reflection, and having analysed data, how leadership manifests itself appears to differ at different levels within organisations. What would have therefore possibly generated additional information and strengthened findings would have been the introduction of a fourth phase of study at charge nurse/team leader level. This would possibly have added additional perspectives to the study and additional knowledge and insight in relation to study findings. An additional limitation but also a positive attribute was the influence of the researcher on the research, research

process and possible outcomes. The next section will consider reflections on the study.

Reflections

I decided to consider this section from two perspectives; one as a researcher and one as a senior manager who has worked in the NHS for over 27 years and both of which we could assume would impact on how I approached the study, how the study was conducted, and possibly analysed and commented on.

In conducting this research again I would approach it differently but this is with the benefit of hindsight and knowledge of the results obtained. Possibly I would choose one health board area undertaking a more in-depth study, or continue with two boards but utilise quantitative and qualitative elements which may strengthen findings. However the most likely change would be to add a fourth phase to the study, interviewing ward leaders and first line managers which I think would then provide an overview of nursing leadership across the whole organisation.

Originally I set out to conduct two case studies in three phases with the aim of the first phase being to contextualise the study, gathering information about the area, organisation and executive team's views regarding leadership and nursing. The questions asked were very similar to those I anticipated to ask in the next two phases although these were intended to be refined as part of the grounded theory process. In practice this did not go to plan. The information and data gathered from the first phase was considerable and not just contextual in nature and therefore I decided to aggregate data into the next two phases rather than this forming a separate section within the data analysis which was the original intention. This highlighted the importance of thinking through more fully the possibilities that may arise from data collection; the need to be flexible in responding to the possible need to refine and change direction within the study; perhaps the need to be more prescriptive in sampling; and the importance of closely considering study design

and who is interviewed to ensure maximum generation of relevant data. This reflects the tensions referred to by Strauss and Corbin (1990) in trying to achieve a balance in being scientific and being creative. In terms of sampling I considered it essential to include executive teams and therefore potentially some non nurses or clinicians in interviews, both to set external and internal context, provide views on leadership, perceptions of their own roles in this process and particularly in respect of the issues for nursing. Indeed the study benefited significantly from this. However this did make decisions on analysis more challenging. I did consider that I possibly should have studied nursing exclusively or considered generically focusing on leadership in the NHS rather than taking a mixed approach.

Having a fairly relaxed approach to interviews was necessary as respondents often ran late having reduced time which made interviews unstructured and, although I had a topic guide and questions for use as appropriate, some of the best but most difficult interviews to conduct were those where respondents didn't directly answer any questions but entered into a very unstructured conversation. This I found very uncomfortable as the interviewer. Grounded theory proved a good method, providing structure to the wealth of information obtained and allowing me to build on key thoughts and issues. Had I not utilised this method I might not have progressed with as much in-depth questioning in subsequent interviews. Conducting one interview per day in three phases I found important to provide adequate reflection time and to conduct the analysis necessary between interviews.

Analysis was particularly challenging because of the wealth and breadth of data obtained which was not anticipated. I struggled in trying to stay as true to the text as possible ensuring I interpreted respondent's true meaning. Given the wealth of data and what I perceived to be particularly important issues, whilst there were obvious key areas highlighted I found it very difficult making the choice of what issues were not magnified in the discussion as almost all the issues raised by respondents were important issues and would have benefited from in depth

discussion. In undertaking analysis I tried to link key issues together, not distilling or disturbing meaning. However sometimes this was difficult and made analysis at times appear too broad. A balance therefore needed to be struck between not losing individual key points but not taking these in isolation and losing overall context. I attempted to complete each phase and analyse each interview prior to the next. In some cases this was not practical but the process did emphasise the need to move between the field, analysis and reflection in a cyclical as opposed to a linear process. As a member of the NHS I felt particular empathy with some of the issues raised and what leaders were trying to achieve also realising at the same time the enormity of the task in hand and the nature of such disparate organisations.

In short these studies are not neat and do not lend themselves to rigorously quantitative systematic methods. In considering such a broad subject area in such large organisations, as one researcher moving in and out of the area it is difficult if not impossible to accurately assess or reflect the leadership, context or culture of the organisation as a whole. Although, that said, I feel reasonably assured that I was able to obtain and present a fairly accurate snapshot of the overall current environment and leadership in the NHS and nursing.

From a personal perspective I found this a positive study which has contributed to my development as a practitioner, as a leader in the NHS and to what I can hopefully now provide in terms of learning for organisations in developing leaders and leadership.

The study's findings confirmed my initial reasons for doing the study and interest in the subject area. These were that in an organisation like the NHS the importance of good leaders and leadership is critical, not just for direction and vision, but in order to set standards of behaviour for staff and to set out what matters and what is important. Most importantly however my views anecdotally centred on the

absolute critical role one person as 'a leader' can play in staff's job satisfaction and development both as a person and as an employee and the catastrophic effects that this can have when the wrong staff are employed in posts who lack the right skills, styles and behaviours. I feel having conducted this study and in my role as a senior leader I will now be able to influence how these issues are taken forward within the health service as a whole.

What has been perhaps surprising but interesting and reassuring is the importance placed on values and what leaders are like as people as opposed to whether they have vision and are able to develop services effectively. I think this has considerable implications for the NHS in terms of developing leaders and leadership and in terms of recruitment and is something that government and policy makers need to take into account when articulating the need for change, efficiency and effectiveness together with the need to value employees; as seen in this study some of the associated behaviours within these objectives do not sit comfortably together. If you ask employees what they value this appears to differ from what is espoused and no leader is able to effect change and development without positive and valued employees which then contribute to the development of a positive working environment.

Considering issues related to my current post and perceived seniority within a health board and possible effects on this study was interesting and was something I had considered in relation to methods, analysis, ensuring validity and objectivity. However it was not something I had considered in terms of access, success of the study, sample size and how the study was perceived by chief executives and directors. Yet this clearly was a factor that worked very notably and positively in my favour, to the extent that I would question someone from outside the NHS or in a more junior role being able to conduct the study; being able to manoeuvre their way round organisations, and organisational politics; have the confidence to pursue particular objectives and respond to complex questions from senior managers.

What became apparent was that being a manager, a nurse and a consultant in a senior position made a significant difference in terms of access and how I was treated. Access for the study was initially made via chief executives who discussed the study and delegated further decisions and discussion to their directors of nursing. In one or two cases following lengthy discussion about how and what I was proposing to do suggestions were made as to who I might approach. Whilst being extremely helpful there was an element of being directed in a certain way which in particular cases I disagreed with and to which I needed to clearly articulate why. Access would have undoubtedly been much more difficult for someone not familiar with the NHS, how it functions and the associated politics, starting from the importance of the first letter, how it was worded and what was emphasised. In order to support the study and sample suggestions I needed to have understanding of nursing, leadership, roles and the NHS. In many interviews people were very busy; there were constant interruptions and emergencies which could have been very difficult for someone not used to operating in these sorts of environments. Furthermore the credibility of my role definitely contributed in terms of the interviews, how I was perceived, what people said and divulged and how they said it. Being regarded as an 'insider' of the NHS family brings with it a certain knowledge and credibility and unwritten acknowledgement which affects even replies to phone calls or e mails, and with regard to how helpful and supportive people are. I doubt this would have applied to someone outside the system who would have been regarded with much more caution. Likewise the first approach to a health board which was denied raises issues and possibilities around organisations thinking of insider research and knowledge.

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Appendix 1

Interview schedule

Introduction notes:

- Consent form
- Purpose of interview
- How the interview will run
- Length
- Format – sections,- I am interested in your views about leadership but I am interested in asking a few specifics as well so there'll be a combination of open and particular questions
- No right/wrong
- Tape, notes.
- All information is in confidence and there will be no reporting of information that will be attributable to any one individual.

Personal Details

- Senior manager, mid - tier
- Length of experience
- Clinical role or not
- Background
- Rough age

Interview schedule

SECTION ONE

Introduction:

1 Looking at the organisational chart at the start of the interview – can I just ask a few questions for context and clarity

2 Tell me about what you think are the key characteristics of a leader?

SECTION TWO

General NHS

1 Have recent reforms increased the focus on leadership?

In what ways and how? Can you give me an example?

Do you feel you do more of…..

Behaviours, approaches, new roles, structures

2 What difference has it made if anything to the way things are done?

3 What differences has it made if any to the way you do your job and the way you work?

4 What have been the main challenges in increasing / improving leadership roles within your organisation?

5 What do you think have been the main benefits/ impact (if any) of this?

6 Emphasis of leadership on patient care? Can you give any examples?

SECTION THREE

The organisation

1 Could you tell me a bit about the history of the organisation?

The structure , how things work?

2 Where do you see leadership sitting / fitting within the organisation?

3 In general how are decisions made?

If you decided to change the role of nurses, talk me through the process, who / what would be involved?

Interview schedule

SECTION FOUR

The organisation and leadership

1 How do you see your leadership role within the organisation?

2 What are you looking to achieve as a leader – personally for your working relations and for the organisation?

3 What's your own personal leadership style?

4 Why do you adopt that style?

5 Do you see any relationship between your leadership role and approach and influencing the leadership style of the organisation?

Tell me why or how ….

6 Do you consciously change your leadership style, and if so under what circumstances?

Influences, personality, the organisation

7 Do you think there are inconsistent leadership styles within the organisation?

Say one thing do another…

8 Well how's this come about?

9 What supports leadership?

10 What constrains it?

SECTION FIVE

Culture and climate

1 In your opinion what are the general characteristics of organisational culture?

2 What do you think the characteristics are within your own organisation?

3 What makes up a positive organisational culture?

4 How do you set up a conducive culture/climate?

5 What role do you think it plays in setting the scene for the priority given to leadership?

Interview schedule

SECTION SIX

Leadership and nursing

1 We've talked generally about leadership - do you think leadership in nursing is more or less important than in the rest of the organisation?

Can you give me an example of why you say that?

2 On balance is leadership stronger in nursing than in other disciplines or the rest of the organisation?

3 What are your expectations of your nurse leaders?

4 Do you feel there are any different issues for nursing in terms of leadership?

5 What specifically is needed to improve leadership in nursing?

Summary

1 At the end of the day do you think this emphasis on leadership is being overplayed?

2 Do you think there are other things that are more important in the delivery of services?

3 What really makes a difference to leadership?

What for you if anything would enable better leadership generally?

4 What would you change?

What are the factors that are going to help?

5 What would you like nurse leadership to look like?

6 If you were running a leadership course in this organisation what content would you include?

7 Overall quality of leadership within your organisation?

Interview schedule

Additional / NURSE LEADER

Introduction notes

SECTION ONE

Introduction:

1 Looking at the organisational chart at the start of the interview – can I just ask a few questions for context and clarity…..

2 Tell me about what you think are the key characteristics of a leader?

SECTION TWO

General NHS

1 Have recent reforms increased the focus on leadership?

In what ways and how? Can you give me an example

Do you feel you do more of…..

Behaviours, approaches, new roles, structures

2 What differences if any has it made to the way things are done?

3 What differences has it made if any to the way you do your job and the way you work?

SECTION THREE

The organisation

1 Where do you see nurse leadership sitting / fitting within the organisation?

2 How do you feel decisions are made generally?

Can you give me an example?

SECTION FOUR

Nurse leadership and the organisation

I would like to move on now to look at leadership in nursing. In order to do that I am going to ask you some general questions around leadership and then explore your views on the same questions but in terms of nurse leadership.

Interview schedule

1 What does leadership mean to you in the context of your current role?

2 What do you think is expected of you as a leader?

3 What are you looking to achieve as a leader?

4 What's your own personal leadership style?

5 Why do you adopt that style?

6 Do you see any relationship between your leadership role and approach and influencing the leadership style of the organisation?

Tell me why or how?

7 Do you consciously change your leadership style, and if so under what circumstances?

Influences, personality, the organisation

How do you learn that?

Just to recap when I asked you what the key characteristics of a leader were you said…..

Just to clarify:

8 Is this what you see as key leadership behaviours?

What do you mean by leadership behaviours?

Can you give me any examples?

How are these demonstrated?

Would this be your idea of a successful nurse leader and the qualities would you look for in one?

9 Are these the same leadership behaviours for nursing?

Is nursing any different?

Are there any issues around nurse leadership in particular?

Can you identify, do you recognise any conflicting aspects of nurse leadership?

10 What in your opinion supports leadership in general?

11 What constrains it?

Can you give any examples?

12 Do you feel there are any different issues for nursing?

13 Can you identify / talk me through a current example of leadership?

What worked well? Not so well? Why?

SECTION FIVE

Personal leadership experiences and thoughts

1 What or who has the most effect in enabling you to achieve your leadership role?

2 What or who has had the most stifling effect?

3 Within your professional life who has influenced you / who do you or have looked up to and why?

4 What was it about that person?

Qualities? Can you give me a description of that person in terms of behaviours and attitudes?

5 What or who influences you now?

If who - who is that and how do they have that effect?

6 Is there anyone you look up to?

How do they have that effect?

How do they motivate you to do things?

Are there people you would do that bit extra for?

How would they get that bit extra from you?

7 How do you get people to look up to you and follow your lead?

SECTION SIX

Culture and climate

1 In your opinion what are the general characteristics of organisational culture?

2 What do you think the characteristics are within your own organisation?

3 What makes up a positive organisational culture?

4 Is the organisational culture important to you in terms of your ability to carry out your leadership role? How?

Please give me some examples?

Thinking back to your success / role – what are / were the key facilitators / drivers present at that time to allow achievement of success?

5 How do you know how to act / what way to go about things?

How do you choose between one option / course of action and another?

SUMMARY

1 What for you if anything would enable better leadership generally?

2 What if anything would you change?

3 What would you like nurse leadership to look like?

4 If you were running a leadership course in this organisation what content would you include?

Interview schedule

DOCUMENTION / OBSERVATION NOTES

- My notes.
- HDLS
- Letters and communications
- Agendas
- Minutes
- Phone calls
- Reports of events
- Administrative documents
- Proposals

Interview schedule

DEFINITIONS

LEADERSHIP

"*Leadership is a process whereby an individual influences a group of individuals to achieve a common goal" (Northouse 1993:3)*

"Leadership is a dynamic situation based social process that is contingent upon culture and context" (Kan 2004)

CULTURE

"The way we do things round here"

"Values, working practices and patterns of behaviour"

"Patterns of shared basic assumptions.. includes observable but also the cognitive and context within"

Three levels have been identified:

Artefacts

Beliefs and values

Assumptions (Schein 1985)

CONTEXT AND CLIMATE

"Perceptions of the observable practices and procedures" (Denison 1996)

Appendix 2

Coding frame

N Analysis

1. Isolated key points / shorter code phrases and in vivo codes

ID	*TEXT*	*CODE / INTERPRETATION / MEANING OF THEME*

2. Relationships in diagrams / networks

Coding frame

3. Focused coding / grouping together all common codes/themes into concepts

concept / statement
codes
concept / statement
codes
concept / statement
codes
concept / statement
codes

Coding frame

4. a. Grouping concepts into categories

code	*statement/concept*	*category*

4. b. Axial coding : diagrammatically illustrating how you arrive at a category / thematic network analysis

- Specifies the properties and dimensions of a category
- To relate / links categories to sub categories and asks how they are related
- Inclusive analytical framework that interprets what is happening
- Makes relationships between implicit processes and structures visible

Diagrammatically illustrating how you arrive at a category (refer to the when, where, how, who and elaborating on a category)

5. Theoretical coding / emergent core categories grounded theory in the data

- How the substantive codes may relate to each other to be integrated into a theory
- By linking the categories and investigating the connections between concepts the theory emerges

Appendix 3

Coding framework and process of analysis

N7 P1- C2 ANALYSIS

1. ISOLATED KEY POINTS AND *IN VIVO CODES*

ID	*TEXT*	*CODE/INTERPRETATION/ MEANING OF THEME*
K1	The most important thing for me is integrity. Actually testing out myself personally about what was the sort of leadership style, what was the values of the chief executive in particular I think it's also very important that leadership delivers and so the kind of walking the talk, actually being consistent. I think people who are relatively junior mix up that kind of grounded consistency with and the not understanding how you then have to work in a very political way. So for me people who are really effective leaders are ones who have lots of different tools, lots of different approaches that they can apply in different settings with different people. But that doesn't affect their integrity. Clearly I would approach a group of disaffected consultants differently to how I might work with my immediate team but still try to achieve the same things and I would still be honest in how I'm dealing with those things. Really good leaders actually spend more time diagnosing how to approach things and bringing out whatever they think is going to work for that situation rather than others who have this is the way I am and I am going to carry on being like this regardless. And I think that is a real skill in terms of people who know what to do, when to do it, when not. Sometimes being a strong leader is actually not doing anything at all and not allowing yourself to be bounced into taking action when actually being still is important. The real test of a good leader is how they respond in adversity. In terms of having tenacity to pick themselves up and have another go and find another way round rather than being beaten by hurdles but it's also about how they protect others from difficulties knowledge in context rather than being really about Your skills and attitudes and behaviours. I think all it does is it requires you, and this is about self diagnosis, it's about really understanding the system and therefore what is likely to work and what isn't	*Leadership characteristics* Integrity most important Also values based – not just style but values associated are most important. That leadership delivers, Political astuteness, having lots of different tools you can mix and match which you can apply depending on person and setting but that doesn't affect their integrity. Approach would be different but would still want to achieve the same things and would still be honest in dealing with. Honesty. Diagnosing problems and deciding then what will work in that situation – so interpretation. *Sometimes being a strong leader is actually not doing anything at all and not allowing yourself to be bounced into taking action when actually being still is important. The real test of a good leader is how they respond in adversity* How they respond in adversity – i.e. they find another way and or are determined and go on regardless. About self diagnosis, it's about really understanding the system and therefore what is likely to work and what isn't *One of the things I say to staff when I meet them is actually I'm only here to make you look good; I'm not here to make me look good. If I am doing things that are making your life more difficult then I'm doing the wrong thing.*
K2	Experience of a number of leadership development programmes, -it was a combination of skills and knowledge but also about personal development and Personal effectiveness. I also did a Masters in managing change and actually took the opportunity in that to really look into effective leadership. And again, an awful lot of personal reflection around behaviours and so actually not just learning from a theoretical basis but choosing to apply it in practice. I think there is a lot that can be taught, I think there	*How learn leadership skills* Combination of knowledge, skills, experience, leadership development programmes, personal reflection around behaviours, not just learning from a theoretical basis but choosing to apply it in practice *A) I think there is a lot that can be taught, B) I think there is a lot to observe from role models and*

	is a lot to observe from role models and case studies of good and bad leadership all over in the public and private sector and there is a tremendous amount of written work/material on leadership of varying quality but I think at the end of the day it's about implementing it in practice. You can adopt leadership behaviours and for me, my personal mantra is the one thing we all have is choice and the only thing we ever have full control over is ourselves and therefore you choose what kind of a leader you want to be or not.	*case studies of good and bad leadership all over in the public and private sector and C) there is a tremendous amount of written work/material on leadership of varying quality D) but I think at the end of the day it's about implementing it in practice. My personal mantra is the one thing we all have is choice and the only thing we ever have full control over is ourselves and therefore you choose what kind of a leader you want to be or not.*
K3	Some of the challenges we have is how we can get People to want to develop and want to reflect and want to be better without them having to go through particularly adverse situations, which force them.	*Leadership challenges* How we can get people to want to develop and want to reflect and want to be better without them having to go through particularly adverse situations, which force them.
K4 *K5*	The things I think are important in leadership are applicable regardless of the setting. A) I would like to think that nurses with the way they have been trained and education, you would hope would be reflective practitioners who would also have very highly developed assessment skills who you think would be able then adopt some of those into their leadership roles. Sadly though, I think there are just as many nurses as there are other professions who aren't reflective, who don't actually understand accountability and if you didn't understand that as a practising staff nurse you're not going to understand it any better in a more senior leadership role. B) I also think that culturally there is a lot of problems in nursing in terms of not really liking good leadership. C) There is a lot of passive aggressive behaviour in nursing as a profession that actually doesn't want to see people be successful and therefore there are poor role models around and there are a lot of people who get quite a lot of stick for actually trying to provide leadership. There's a bit of a sense of that in the NHS generally. I think it is even more pronounced in Scotland than England because there is a bit of a sense of nobody should be any better than anybody else and therefore if you put yourself forward you are a bit cocky. I suspect there is some gender stuff in there as well but I do think, whereas in other professions success is rewarded more so I think There is a whole lot of cultural stuff that goes on. I think a lot of nursing is still regarded as very hierarchal and therefore it is an assumption that to be providing leadership you must be in a senior role when in fact actually some of the greatest leaders we have will not be in a positional role but will have huge potential and exert that. In practice I have never let my position get in the way of what I was trying to if it was the right thing for patients. I would never be anybody who was waiting for permission or waiting to be told to do something, if I thought it was right for the patient then I would be motivated to try to do it and would apply the same thing to my own career so I have had personal experience of being in positions where people I	*Leadership in nursing* Nursing is no different, but with the training there is some thought that they should be more reflective with highly developed assessment skills *Sadly though, I think there are just as many nurses as there are other professions who aren't reflective, who don't actually understand accountability and if you didn't understand that as a practising staff nurse you 're not going to understand it any better in a more senior leadership role*. Cultural problems like, nurses not really liking good leadership or people that do well & therefore there are poor role models around. Success more rewarded in other professions. Gender issues. *Nurses and leadership* Do nurses know what leadership is? Due to the hierarchical nature of nursing leadership is still regarded as a senior phenomenon. Those who are leaders will be leaders despite the structures. Although an important need is to play the hierarchy. Is this just an attribute or characteristic though of leaders that they find ways despite?? This sort of professional jealousy in nursing then to those that do that and then sometimes find themselves in leadership positions - also a reason way nurses may not want to go into leadership positions - loss of peers, seen in a different light, them and us - this really needs to

	know have said how has she got there, she hadn't been up the right ladder, how could that have possibly happened and actually tried to sabotage me as a result but my response is always well I'm just going to do this so well there is nothing you can do about it. But that does take a kind of personal groundedness to be able to do that.	be addressed in nursing. Where does it come from??
K6	The policy agenda is about is transformational change and for that you need transformational leadership and the old sorts of models, the NHS for years was just administered it wasn't led and everybody's job was just keeping under control rather than to change but actually the reforms has kind of blown that apart.	*Reforms* *The policy agenda is about is transformational change and for that you need transformational leadership and the old sorts of models, the NHS for years was just administered it wasn't led and everybody's job was just keeping under control rather than to change but actually the reforms has kind of blown that apart.*
K6a	With that change a lot of the old hierarchies have gone, a lot of the typical pathways have gone and so its allowed people to emerge as leaders who perhaps are not in the power position necessarily or the power Shifts in different ways and I think people are given opportunities to step up to the mark if they choose to.	More opportunities for leadership
K6b	I also think that there has been an improvement in leadership behaviours adopted by senior people which then enables and empowers others to do that because Actually it takes a very special kind of person to really be empowered in a very controlling hierarchal organisation. Even here, even in 18 months people are saying there is a tangible difference in terms of the culture as a result of my leadership and that provided by my team and that nursing feels much more valued in a sense of more congruity between what the organisation wants and what they want. I don't know if that has fundamentally changed but how its expressed, how they understand it, how its portrayed is now more clear for people at a more junior level to see and a much stronger sense of accountability that has cut across from a patient perspective in a very helpful way, across a very strong general management culture. So nurse leaders are emerging and having the confidence to do so. This was me exerting professional leadership in an area I am professionally accountable for and you will and I won't let it go until you do. And that I think gave people.... working in teams but people said you know in the past that wouldn't have happened	Mixed views re reforms – notably those re nursing have had a big influence – those in general felt to not really have had an influence on leadership but have influenced the context. Also important how the top team behaves also needs to change to allow leadership to flourish In one case little structurally had changed but the style and visibility of the leadership which has had dramatic effect – in question to what exactly is different – accountability, visibility, cultural difference about what's expected. This has then also had an effect on those wanting to come forward into more leadership roles Demonstrating / exerting professional leadership & about instilling a culture of accountability *It's that kind of behavioural stuff that does have an impact because then it makes others in the chain think well if there is something that I think is really important, even if people don't, I need to keep at it, I can't just shrug my shoulders it and go back into the ward.*
K7	If you look at a lot of the change that's been delivered, in a lot of the cases its people with a	*Impact on patient care* Often nursing has seen the

	nursing background, not necessarily in a nursing role but Bringing all the skills that they've acquire as nurses and the applying them into a new setting and have driven a huge amount of change for patient benefit.	biggest opportunities and had a considerable impact on patient care
K8	The rules, the policies, the structures, the culture are all different and that requires you to work in different ways because there are different leavers, different motivators, different rewards but that is just kind of knowledge in context rather than being really about Your skills and attitudes and behaviours. I think all it does is it requires you, and this is about self diagnosis, it's about really understanding the system and therefore what is likely to work and what isn't.	*Effects on role* Adapted and adopted different behaviours but that's not new
K9	I always try to go back to first principles and that gives you then a way through because the detailed knowledge is the easiest thing in the world to acquire, you can go and read a book, you can go and talk to an expert, there's always somebody. I'd never had Mental health responsibilities before I came here, I am now chief operating officer for, part for mental health, division but I can think through my leadership role in relationship to that without knowing everything about the mental health act.	*Leadership role* Leadership not about knowledge but credibility which is different
K10	So there positioned quite strongly and they are professionally accountable to me but line managed through the general manager. That's really important and whilst I've talked a lot before about you don't Need position actually in the organisation terms you do. So strategically nursing needs to be positioned so it can influence. It then needs to have the confidence to exert the influence it's got so you need both.	*Nursing leadership* Sits very clearly at all levels and its very visible. Whilst structure is thought not to effect leaders then ability to change things and make a difference – in terms of organisation in a key leadership role position is very important Also very important the link to the top. *Strategically nursing needs to be positioned so it can influence. It then needs to have the confidence to exert the influence it's got so you need both.*
K11	*I would say your chief nurse is the person who will Keep you out of jail, your general manager will make the books balance but unless things go really badly wrong not many chief executives get sacked because the money is not right. But they get sacked if the care isn't right. It's all those sort of things which actually a general manager couldn't possibly understand and actually, even if they did, I don't believe that any one person can hold that total ring as effectively as a partnership can.* While you are looking at the money, you also need to be looking at the quality and actually if you get the quality right the money follows because we waste more money in getting things wrong that we spend in getting it right and it will be a clinician exerting.... The thing with chief executives is a) you've got to speak their language and relate things To what you're going to do for them. And if they've never seen good nursing leadership they are not going to value it and for some people it's more difficult going into an organisation because they won't' value because it has been crap. Poor nurse leadership is just as bad	*Nursing leadership & importance of* *I would say your chief nurse is the person who will* *Keep you out of jail, your general manager will make the books balance but unless things go really badly wrong not many chief executives get sacked because the money is not right. But they get sacked if the care isn't right. It's all those sort of things which actually a general manager couldn't possibly understand and actually, even if they did, I don't believe that any one person can hold that total ring as effectively as a partnership can.* Issues in the past lots of very senior poor nurse leadership and repercussive effects is that if you've not had it you don't miss it or value it – if you've had it & it's

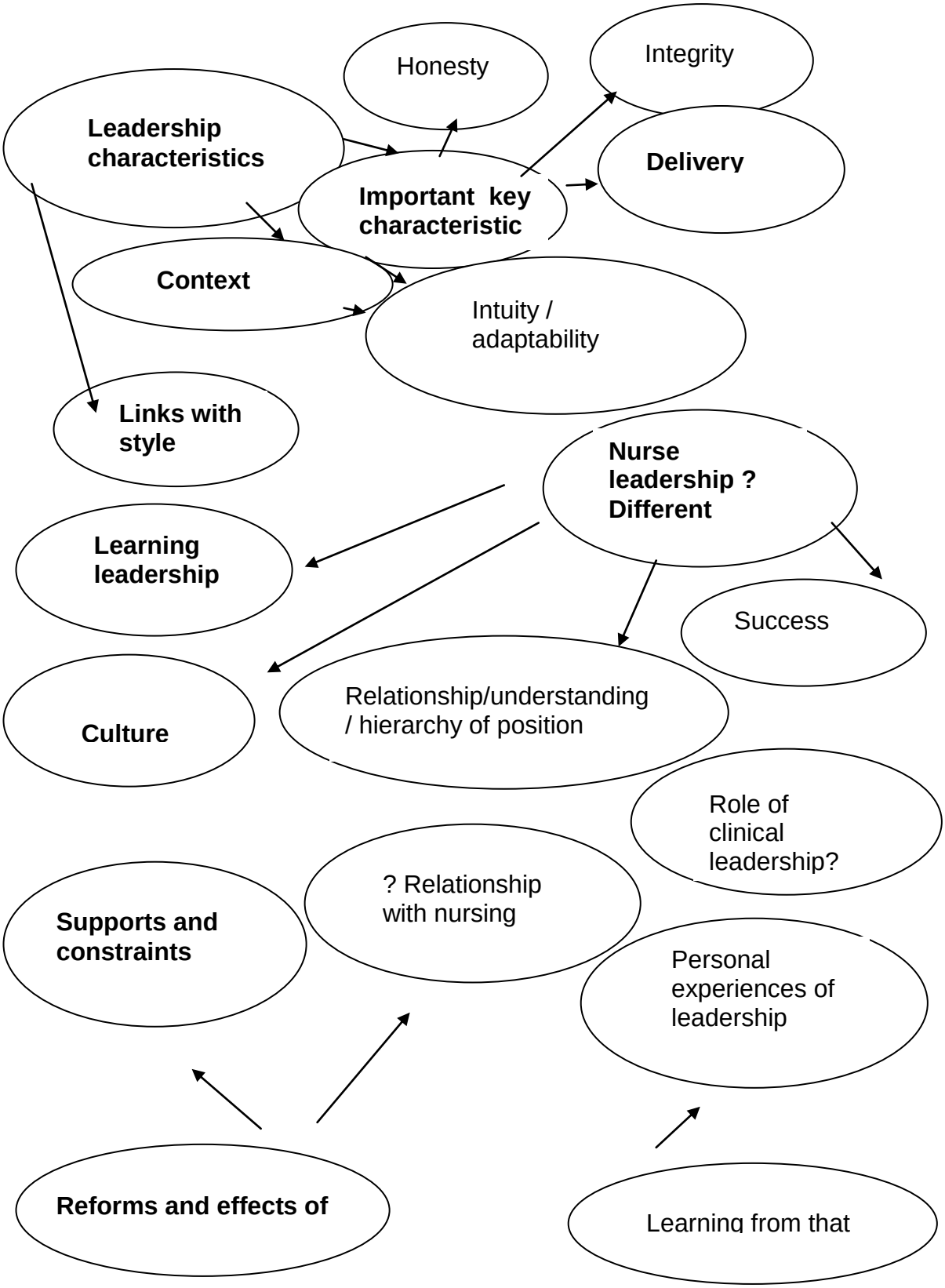
	as poor chief executive leadership and there's been to be fair, in the past a lot of poor, nurses not exhibiting good leadership in senior positions so why would you want one but if you get a good one and you suddenly see what it can do then you would want one.	been bad you don't value it
K12	*People need to feel my presence rather than see my face* There is a very practical issue of trying to provide professional leadership to about 12 thousand staff most of whom have never met me and most are unlikely to. Quite important because as a staff nurse you are likely to value somebody who is helping you do your job directly and they can't see... So I think a really important job for me is translating policy and strategy and corporate objectives and organisational objectives into things that are meaningful to the staff. I'm there as a translator, I'm there to represent nursing and to ensure nursing and AHPs have a voice at the Board and are seen as an effective contributor. I also Have to be contribution right across the agenda and have to own all of those, decisions. I think a lot of it is about good communication but it's about giving people the confidence, putting a bit of an umbrella around people and giving them a bit of space and security that we will support them and it is worth making the effort and keeping going This is a lovely phrase – leadership is about lighting the fires while managing is About going over and putting them out. And so for me it's inspiring people its sparking people whereas if you are a middle manager you actually just want them to be quiet, everything's under control and that's great and don't ruffle any feathers and I think that's why middle managers struggle with their leadership roles because I think they think they want the organisation wants them to just manage and actually what we want them to do is lead as well	*Leadership role* *Part one* A. Providing professional leadership B translating policy and strategy and corporate & organisational objectives into meaningful things C translating and interpreting and instilling the importance and relevance of There as a translator, to represent nursing and to ensure a voice at the board and are seen as an effective contributor *Part two* Corporate role. Contribute and own all decisions, good communication, giving people confidence and security, inspiring people. *Leadership is about lighting the fires while managing is* *About going over and putting them out.*
K13	one of the attributes of a good leader is I set very high standards .for me part of my role is getting people to up their game and raise their standards and so they become dissatisfied with the status quo or dissatisfied with average	*Aims of a leader* Set very high standards, getting people to raise their game so they become dissatisfied with the status que
K14	I am empowering, I think I am a very good listener, I never assume I know, I always check, I am a great believer in teams and particularly in nursing, collective strength is phenomenal, but we are so easily divided and therefore and so on so I really work hard on teams. I think I am very astute, I think I've got a good level of emotional intelligence in terms of applying myself differently. I think I am very open and honest Then as I became more confident I could actually allow more of me to come through because she was saying she knew me. Very calm and in control which again gives people confidence. For me ambiguity means options and choice and I love change. So I think in my style people would see me as professional, honest, again integrity would be very important and I think people do see that so they trust me. And that trust then allows them to work with me because when the push comes to	*Leadership style* Listener, empowering, astute, adaptable style, open and honest, shows the human element, calm & in control, integrity, trust *For me ambiguity means options and choice and I love change. So I think in my style people would see me as professional, honest, again integrity would be very important and I think people do see that so they trust me. And that trust then allows them to work with me because when the push comes to shove, if I actually think something is too risky then we won't do it. But I will push people right to the edge to test it.*

	shove, if I actually think something is too risky then we won't do it. But I will push people right to the edge to test it.	
K15	No time for are the people who are disingenuous, the worst thing you can do is lie to me. I am so values based and principle drive, if you do that then you breaks the psychological contract, you are dead in the water. Whereas people you genuinely try, make genuine mistakes, I will support and help carry them through and protect all of those things but if your dishonest, if you've not got patience, if you are very Self interested those are people I have no time for. I suppose the only other thing I would say is I am not ruthless but I'm tough and I'll be very friendly but you don't deliver, you don't do it or you do something I believe is dishonest and I'll have you and I'll make sure its seen right through because I can't allow that sort of behaviour to continue in and organisation And I think that's the only thing that really is important, you have to be able to make the tough decisions and put aside any personal feelings as well.	*Leadership behaviours* Delivery, honesty, genuine, able to take the tough decisions and see them through
K16	I think some cultural stuff about nurses are supposed to be nice and people mix up being nice with being soft. And I think I'm nice but I'm not soft. If you look at different leadership cultures and you look at some of the stuff that would be valued in a business setting, if you go into a business model you suddenly need to develop business behaviours and therefore you get to be like the tough chief executive that will get rid of half the workforce for the sake of shareholders, I actually think that is an outdated model of leadership	*Leadership in nursing* Sometimes mix up nice with soft
K17	a. There's no doubt organisational culture has a huge effect b. The other bit is about the investment in people's personal development and the education and training and development opportunities that supports and facilitates leadership. C. There'll be structural Things that support it. The absolutely determined leader will overcome all of those things; it's much easier if things are set up to make life easier for people rather than more difficult. D. Again it's all about rewards in the system, the drivers, the leavers because if good leadership is not rewarded it's not going to flourish.	*Supports and constraints* Organisational Culture, Investment in personal dev, structural things, reward systems
K18	they make their choices not on what's an organisational culture but the culture of the ward or the culture of their department but then what they will do is assign all sorts of behaviours they believe the rest of the organisation. And that's one of the advantages, requirements for me to go out and meet people because they will have attributed all sorts of behaviours to me just because of who I am without knowing who I am at all. And they'll have made all sorts of assumptions about what I care about, what I know about, what I thinks important because it will be them Because that is the great thing in the NHS, there's always a them, even in single system where it's like no it's us. But that is	*Organisational culture* Organisational culture is key in every part of the org but is seen differently by different people. Seems always to be a them and us culture? Reason -? Need someone to blame and be accountable for issues v sorting out and addressing themselves. Really concerns people is what and how things affect them

	meaningless to a staff nurse. What will be important to them is the kind of relationships within the direct team and what they then see as the decisions are then made and handed down that directly affect them. So, in that way the organisational culture is hugely important but they just don't realise necessarily or say I wouldn't describe it as that but that is one of the reasons why I was so pleased to be doing some of this work around the role of the senior charge nurse because in terms of impact their impact for good or ill is phenomenal, and actually we've not spent enough time thinking about their leadership	
K19	About reward systems, physical and emotional, it's about all the morals and mysteries and myths that have developed over the years. It's absolutely about this is the way we do things and of course that's some of the stuff that has to change. In Scotland Everything takes way too long, there's no sense of urgency but then there are, you know in England if you don't sort out some of the stuff then your chief executive will be gone. If you don't hit that target your dead. If you don't get your costs your financially out of a job, it's all a bit mushy here in Scotland.	*Organisational Culture Characteristics of* About reward systems, physical and emotional, it's about all the morals and mysteries and myths that have developed over the years. It's absolutely about this is the way we do things
K20	. I think I have been influenced by a number of people who showed me when I was relatively junior that there were other ways of doing things. So senior people Invested in me and my development had really big impact. Who gave me some really good insights into me which then gave me some options to change some really good chief executives who I've learned, particularly thinking back to when I was in my first Board level job, the chief executive who was really fairly politically astute who taught me an awful lot who'd been though some very difficult, very high profile media experience	*Experiences of leadership* Role models play an important role, investment, personal insight, experience, recognising and nurturing potential
K21	I've got people who still are in touch with me from my first Board level job who, people say they would go to the end of the earth for you. B*ut I think it's because I engage with people on a kind of personal value basis now if they are up for that then they will follow you to the end of the earth, if they're not there probably be nothing I can do but I think it comes because people trust me.* Being prepared to tackle things that need tackling. That's the other bit. So they know , people have said to me the things they've seen different in me is that I'll do what I say I'll do, I'll tackle problems, I won't run away from them but I'll be a supportive colleague, boss, whatever at the same time. Another thing that is probably minor I will always give credit Where it's due rather than take other people's work and claim it as my own. That's really important. But equally I will take the accountability for when things go wrong. I'll never say it wasn't my fault. It's my patch.	*How you then utilise that* What is it about that person?? Interaction, trust, respect, values credibility *But I think it's because I engage with people on a kind of personal value basis now if they are up for that then they will follow you to the end of the earth, if they're not there probably be nothing I can do but I think it comes because people trust me.* Tackling things, delivery, praising people and then taking responsibility when things go wrong This then must instil trust, risk taking and innovative culture
K22	I would like nurse leadership to have more confidence and probably a bit more competence because I have seen very competent people who are hopeless, not as good as they think they are. I would like to see more investment in leadership	*Nurse leadership* Needs more confidence, more investment and not those just who have potential- tendency to invest in the best and therefore people

	throughout for everybody, senior and junior level and I would like it to be seen as something you couldn't do without rather than it being an optional extra for a few bright sparks, routine and Invested in because I think it would pay dividends. I would like to see nursing leadership having the confidence to work with others better I think we still tend to huddle together, for safety, So I think it's a bit about how its, it's about where we get mixed up between leadership development management development and personal progression and with a bit of sense if you send your best people which you know is understandable because of limited opportunities you invest in the best who then move on so people see leadership and a good way to get a better job next time around. Rather than saying actually we need really good leadership, with all the people staying exactly where they are doing a really good job and helping them to do an even better one.	see leadership as a way of moving on v as a key necessary skill we all need to have and encouraging people to stay where they are and do a brilliant job

2. RELATIONSHIPS IN DIAGRAMS / NETWORKS



3. *FOCUSED CODING / GROUPING TOGETHER ALL COMMON CODES/THEMES IN TO CONCEPTS*

CONCEPT / STATEMENT
Leadership characteristics
Integrity most important Also values based – not just style but values associated are most important. That leadership delivers, Political astuteness, having lots of different tools you can mix and match which you can apply depending on person and setting but that doesn't affect their integrity. Approach would be different but would still want to achieve the same things and would still be honest in dealing with. Honesty. Diagnosing problems and deciding then what will work in that situation – so interpretation. *Sometimes being a strong leader is actually not doing anything at all and not allowing yourself to be bounced into taking action when actually being still is important.* How they respond in adversity – i.e. they find another way and or are determined and go on regardless about self diagnosis, it's about really understanding the system and therefore what is likely to work and what isn't *One of the things I say to staff when I meet them is actually I'm only here to make you look good, I'm not here to make me* *Look good. If I am doing things that are making your life more difficult then I'm doing the wrong thing.*
CODES
K1
CONCEPT/STATEMENT
How learn leadership skills
Combination of knowledge, skills, experience, leadership development programmes, personal reflection around behaviours, not just learning from a theoretical basis but choosing to apply it in practice *A) I think there is a lot that can be taught) I think there is a lot to observe from role models and case studies of good and bad leadership all over in the public and private sector and C) there is a tremendous amount of written work/material on leadership of varying quality D) but I think at the end of the day it's about implementing it in practice* *my personal mantra is the one thing we all have is choice and the only thing we ever have full control over is ourselves and therefore you choose what kind of a leader you want to be or not.*
CODES
K2
CONCEPT/STATEMENT
Leadership challenges
How we can get people to want to develop and want to reflect and want to be better without them having to go through particularly adverse situations, which force them.
CODES
K3
CONCEPT/STATEMENT
Leadership in nursing
Nursing is no different, but with the training there is some thought that they should be more reflective with highly developed assessment skills *Sadly though, I think there are just as many nurses as there are other professions who aren't reflective, who don't actually understand accountability and if you didn't understand that as a practising staff nurse you're not going to understand it any better in a more senior leadership role*. Cultural problems like, nurses not really liking good leadership or people that do well & therefore there are poor role models around. Success more rewarded in other professions. Gender issues. ***Nurses and leadership*** Do nurses know what leadership is? Due to the hierarchical nature of nursing L is still regarded as a senior phenomenon Those who are leaders will be leaders despite the structures Although an important need is to play the hierarchy. Is this just an attribute or characteristic though of leaders that they find ways despite?? This sort of professional jealousy in nursing then to those that do that and then sometimes find themselves in leadership positions – also a reason way nurses may not want to go into

leadership positions – loss of peers, seen in a different light, them and us – this really needs to be addressed in nursing. Where does it come from??

Nursing leadership

Sits very clearly at all levels and its very visible. Whilst structure is thought not to effect leaders then ability to change things and make a difference – in terms of organisation in a key leadership role position is very important Also very important the link to the top. *Strategically nursing needs to be positioned so it can influence. It then needs to have the confidence to exert the influence it's got so you need both.*

Nursing leadership & importance of

I would say your chief nurse is the person who will

Keep you out of jail, your general manager will make the books balance but unless things go really badly wrong not many chief executives get sacked because the money is not right. But they get sacked if the care isn't right. It's all those sort of things which actually a general manager couldn't possibly understand and actually, even if they did, I don't believe that any one person can hold that total ring as effectively as a partnership can.

Issues in the past lots of very senior poor nurse leadership and repercussive effects is that if you've not had it you don't miss it or value it – if you've had it and it's been bad you don't value it

Leadership in nursing

Sometimes mix up nice with soft

Nurse leadership

Needs more confidence, more investment and not those just who have potential- tendency to invest in the best and therefore people see leadership as a way of moving on versus as a key necessary skill we all need to have and encouraging people to stay where they are and do a brilliant job

CODES

K4, K5, K10, K11, K16, K22

CONCEPT/STATEMENT

Reforms

The policy agenda is about is transformational change and for that you need transformational leadership and the old sorts of models, the NHS for years was just administered it wasn't led and everybody's job was just keeping under control rather than to change but actually the reforms has kind of blown that apart. Mixed views re reforms – notably those re nursing have had a big influence – those in general felt to not really have had an influence on leadership but have influenced the context. Also important how the top team behaves also needs to change to allow leadership to flourish

In one case little structurally had changed but the style and visibility of the leadership which has had dramatic effect – in question to what exactly is different – accountability, visibility, cultural difference about what's expected. This has then also had an effect on those wanting to come forward into more leadership roles. Demonstrating / exerting professional leadership & about instilling a culture of accountability *It's that kind of behavioural stuff that does have an impact because then it makes others in the chain think well if there is something that I think is really important, even if people don't, I need to keep at it, I can't just shrug my shoulders it and go back into the ward.*

More opportunities for leadership

CODES

K6, k6a,k6b

CONCEPT/STATEMENT

Impact on patient care

Often nursing has seen the biggest opportunities and had a considerable impact on patient care

CODES

K7

CONCEPT/STATEMENT

Effects on role

Adapted and adopted different behaviours but that's not new

Leadership role

Leadership not about knowledge but credibility which is different

CODES

K8,K9

CONCEPT/STATEMENT

Leadership role

Part one

A. Providing professional leadership B translating policy and strategy and corporate and organisational objectives into meaningful things C translating and interpreting and instilling the

importance and relevance of There as a translator, to represent nursing and to ensure a voice at the board and are seen as an effective contributor ***Part two*** Corporate role Contribute and own all decisions, good communication, giving people confidence and security, inspiring people. ***leadership is about lighting the fires while managing is*** ***About going over and putting them out.*** ***Aims of a leader*** Set very high standards, getting people to raise their game so they become dissatisfied with the status quo
CODES
K12, K13
CONCEPT/STATEMENT
Leadership style Listener, empowering, astute, adaptable style, open and honest, shows the human element, calm and in control, integrity, trust ***For me ambiguity means options and choice and I love change. So I think in my style people would see me as professional, honest, again integrity would be very important and I think people do see that so they trust me. And that trust then allows them to work with me because when the push comes to shove, if I actually think something is too risky then we won't do it. But I will push people right to the edge to test it.*** ***Leadership behaviours*** Delivery, honesty, genuine, able to take the tough decisions and see them through
CODES
K14, k15
CONCEPT/STATEMENT
Supports & constraints Organisational culture, Investment in personal dev, structural things, reward systems
CODES
K17
CONCEPT/STATEMENT
Organisational culture Organisational culture is key in every part of the org but is seen differently by different people. Seems always to be a them and us culture? Reason -? Need someone to blame and be accountable for issues versus sorting out and addressing themselves. ***Characteristics of*** Really concerns people is what & how things affect them About reward systems, physical and emotional, it's about all the morals and mysteries and myths that have developed over the years. It's absolutely about this is the way we do things
CODES
K18, k19
CONCEPT/STATEMENT
Experiences of leadership Role models play an important role, investment, personal insight, experience, recognising and nurturing potential ***How you then utilise that*** What is it about that person?? Interaction, trust, respect, values credibility ***but I think it's because I engage with people on a kind of personal value basis now if they are up for that then they will follow you to the end of the earth, if they're not there probably be nothing I can do but I think it comes because people trust me.*** Tackling things, delivery, praising people and then taking responsibility when things go wrong This then must instil trust, risk taking and innovative culture
CODES
K20, k21

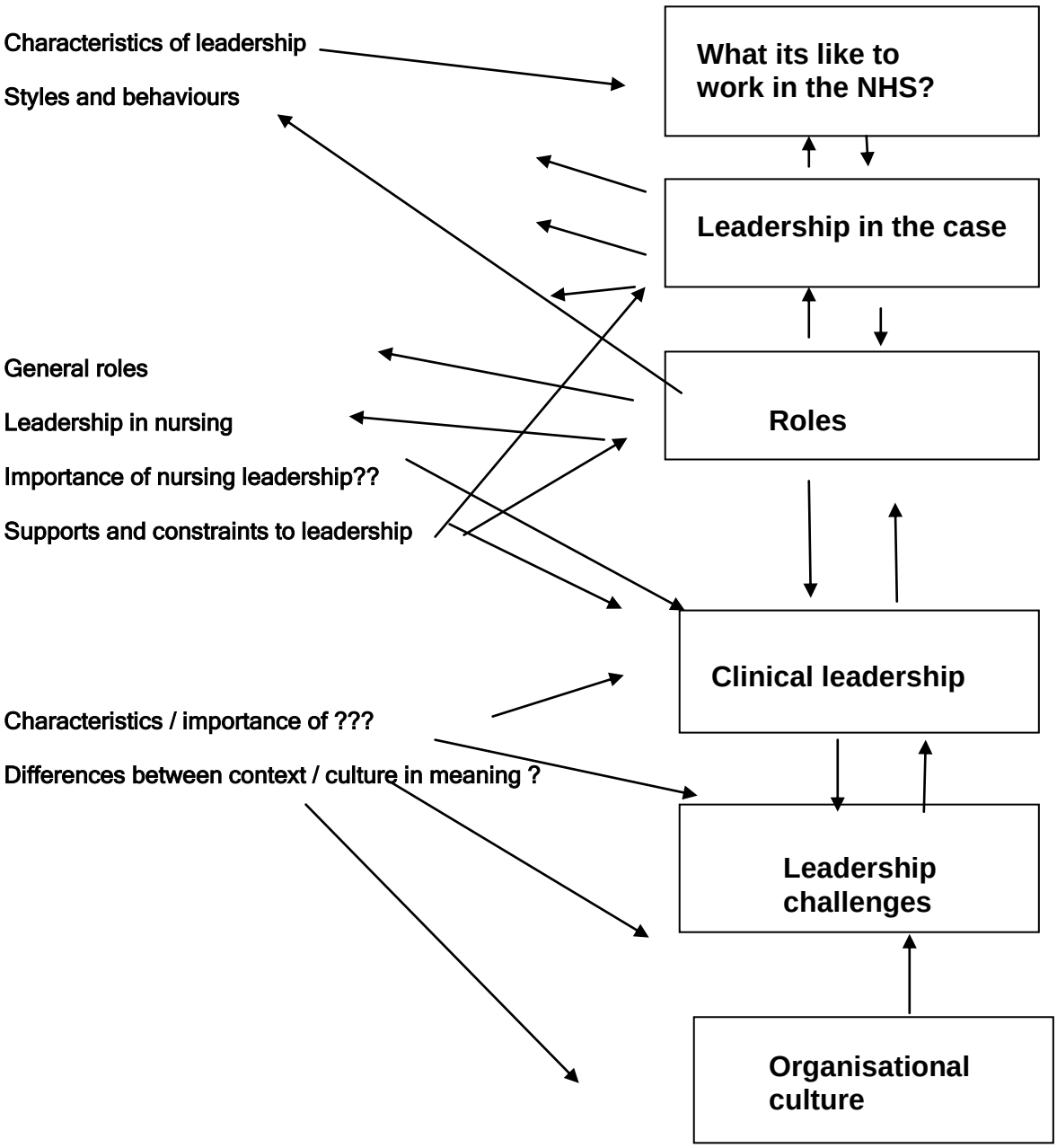
4. A. GROUPING CONCEPTS INTO CATEGORIES

CODE	*STATEMNT/CONCEPT*	*CATEGORY*
K1, K2, K3, K6, K6A, K6B, K7, K8, K9, K20, K21	***Leadership characteristics*** Integrity most important. Also values based – not just style but values associated are most important. That leadership delivers, Political astuteness, having lots of different tools you can mix and match which you can apply depending on person and setting but that doesn't affect their integrity. Approach would be different but would still want to achieve the same things & would still be honest in dealing with. Honesty. Diagnosing problems & deciding then what will work in that situation – so interpretation. *Sometimes being a strong leader is actually not doing anything at all and not allowing yourself to be bounced into taking action when actually being still is important.* How they respond in adversity – i.e. they find another way & or are determined and go on regardless about self diagnosis, it's about really understanding the system and therefore what is likely to work and what isn't *One of the things I say to staff when I meet them is actually I'm only here to make you look good, I'm not here to make me look good. If I am doing things that are making your life more difficult then I'm doing the wrong thing.* ***How learn leadership skills*** Combination of knowledge, skills, experience, leadership dev programmes, personal reflection around behaviours, not just learning from a theoretical basis but choosing to apply it in practice *A) I think there is a lot that can be taught) I think there is a lot to observe from role models and case studies of good and bad leadership all over in the public and private sector and C) there is a tremendous amount of written work/material on leadership of varying quality D) but I think at the end of the day it's about implementing it in practice* *my personal mantra is the one thing we all have is choice and the only thing we ever have full control over is ourselves and therefore you choose what kind of a leader you want to be or not.* ***Experiences of leadership*** Role models play an important role, investment, personal insight, experience, recognising and nurturing potential ***How you then utilise that*** What is it about that person?? Interaction, trust, respect, values credibility *but I think it's because I engage with people on a kind of personal value basis now if they are up for that then they will follow you to the end of the earth, if they're not there probably be nothing I can do but I think it comes because people trust me.* Tackling things, delivery, praising people and then taking responsibility when things go wrong This then must instil trust, risk taking and innovative culture ***Leadership challenges*** How we can get people to want to develop and want to reflect and want to be better without them having to go through particularly adverse situations, which force them. ***Reforms*** *The policy agenda is about is transformational change and for that you need transformational leadership and the old sorts of models, the NHS for years was just administered it wasn't led and everybody's job was just keeping under control rather than to change but actually the reforms has kind of blown that apart.* Mixed views re reforms – notably those re nursing have had a big influence – those in general felt to not really have had an influence on leadership but have influenced the context.	*WHAT IT'S LIKE WORKING IN THE NHS / LEADERSHIP*

	. More opportunities for leadership *Impact on patient care* Often nursing has seen the biggest opportunities and had a considerable impact on patient care *Effects on role* Adapted & adopted different behaviours but that's not new *Leadership role* Leadership not about knowledge but credibility which is different	
K6B	Also important how the top team behaves also needs to change to allow leadership to flourish In one case little structurally had changed but the style and visibility of the leadership which has had dramatic effect – in question to what exactly is different – accountability, visibility, cultural difference about what's expected. This has then also had an effect on those wanting to come forward into more leadership roles. Demonstrating / exerting professional leadership and about instilling a culture of accountability *It's that kind of behavioural stuff that does have an impact because then it makes others in the chain think well if there is something that I think is really important, even if people don't, I need to keep at it, I can't just shrug my shoulders it and go back into the ward*	*LEADERSHIP IN THE CASE*
K12, K13, K14, K15, K17	*Leadership role* *Part one* A. Providing professional leadership B translating policy and strategy and corporate & organisational objectives into meaningful things C translating and interpreting and instilling the importance and relevance of. There as a translator, to represent nursing and to ensure a voice at the board and are seen as an effective contributor *Part two* Corporate role. Contribute and own all decisions, good communication, giving people confidence and security, inspiring people. *leadership is about lighting the fires while managing is About going over and putting them out.* *Aims of a leader* Set very high standards, getting people to raise their game so they become dissatisfied with the status quo *Leadership style* Listener, empowering, astute, adaptable style, open & honest, shows the human element, calm and in control, integrity, trust *For me ambiguity means options and choice and I love change. So I think in my style people would see me as professional, honest, again integrity would be very important and I think people do see that so they trust me. And that trust then allows them to work with me because when the push comes to shove, if I actually think something is too risky then we won't do it. But I will push people right to the edge to test it.* *Leadership behaviours* Delivery, honesty, being genuine, able to take the tough decisions and see them through *Supports & constraints* Organisational culture Investment in personal development, structural things, reward systems	*LEADERSHIP ROLES*
K18, K19	*Organisational culture* Organisational culture is key in every part of the org but is seen differently by different people. Seems always to be a them and us culture? Reason -? Need someone to blame and be accountable for issues v sorting out and addressing themselves.	*LEADERSHIP & ORGANISATIONAL CULTURE*

	Characteristics of Really concerns people is what & how things affect them About reward systems, physical and emotional, it's about all the morals and mysteries and myths that have developed over the years. It's absolutely about this is the way we do things	
K4, K5, K10,K 11, K16, K22	*Leadership in nursing* Nursing is no different, but with the training there is some thought that they should be more reflective with highly developed assessment skills *Sadly though, I think there are just as many nurses as there are other professions who aren't reflective, who don't actually understand accountability and if you didn't understand that as a practising staff nurse you're not going to understand it any better in a more senior leadership role*. Cultural problems like, nurses not really liking good leadership or people that do well and therefore there are poor role models around. Success more rewarded in other professions. Gender issues. *Nurses and leadership* Do nurses know what leadership is? Due to the hierarchical nature of nursing L is still regarded as a senior phenomenon Those who are leaders will be leaders despite the structures Although an important need is to play the hierarchy. Is this just an attribute or characteristic though of leaders that they find ways despite?? This sort of professional jealousy in nursing then to those that do that & then sometimes find themselves in leadership positions – also a reason way nurses may not want to go into leadership positions – loss of peers, seen in a different light, them & us – this really needs to be addressed in nursing. Where does it come from?? *Nursing leadership* Sits very clearly at all levels and its very visible. Whilst structure is thought not to effect leaders then ability to change things and make a difference – in terms of organisation in a key leadership role position is very important Also very important the link to the top. *Strategically nursing needs to be positioned so it can influence. It then needs to have the confidence to exert the influence it's got so you need both.* *Nursing leadership & importance of* *I would say your chief nurse is the person who will* *Keep you out of jail, your general manager will make the books balance but unless things go really badly wrong not many chief executives get sacked because the money is not right. But they get sacked if the care isn't right. It's all those sort of things which actually a general manager couldn't possibly understand and actually, even if they did, I don't believe that any one person can hold that total ring as effectively as a partnership can.* Issues in the past lots of very senior poor NL & repercussive effects is that if you've not had it you don't miss it or value it – if you've had it and it's been bad you don't value it *Leadership in nursing* Sometimes mix up nice with soft *Nurse leadership* Needs more confidence, more investment and not those just who have potential- tendency to invest in the best and therefore people see leadership as a way of moving on v as a key necessary skill we all need to have and encouraging people to stay where they are and do a brilliant job	*LEADERSHIP IN NURSING*

5. B. AXIAL CODING : DIAGRAMATICALLY ILUSTRATING HOW YOU ARRIVE AT A CATEGORY



6.THEORETICAL CODING

Complete at end of phase - join transcripts and compare categories

Appendix 4

Leadership styles

Leadership style	
Approachable	Open to challenge
Engaging	Values people with different styles
Clear expectations	Not always in control
Firm	Consistency
Fair	Reflects values
Lets people get on with it	Humour
Monitors	Understanding and reflects seeing world
Collaborative / consultative	from their perspective
Involving	Touchy feely
Directive when needed	Transactional and transformational
Opinionated but willing to listen	Open
'Care ability'	Honest

Appendix 5

Leadership behaviours

Leadership behaviours	
• Open and honest • Genuine • Delivering • Empowering • Credible • Respectful • Giving consistent messages • Risk taking	• Giving people the autonomy 'to do' • Taking decisions • Having positive regard • Being tenacious • Determined • Manipulative

Appendix 6

Learning leadership

How do you learn leadership?	
• From experience • Reflection away from the workplace • Trial and error • Observation • Practice • Organisational development • Role models • Innate qualities	• Being in the right environment • Taking risks and working a bit differently • By devolving responsibility to others • By instilling confidence • Getting feedback • Mentorship

Appendix 7

Organisational culture

Definitions of organisational culture

- A way people do things
- The way people think and behave
- Style and content of organisations
- Kinds of behaviours: 'what's acceptable and what's not'
- Norms ,values and attitudes
- Morals, mysteries and myths
- Values of the organisation
- Beliefs and how people view the world which results in certain behaviours
- Joint ways of thinking, acting, behaving
- How people behave towards each other

Appendix 8

Culture and leadership

Types of leadership associated with cultural type

- *Culture in clan cultures are internally focused and process orientated, reflected in concerns for employee loyalty, commitment and group cohesion and the focus is on maintenance of internal of organisational relations. Leaders are viewed as supportive and facilitative*

- *The developmental / open culture emphasises innovation and leadership is viewed as visionary and willing to take risks. Leaders concentrate on attaining organisational legitimacy and external support. The climate is described as dynamic and stimulating, promoting creativity.*

- *Hierarchical culture values predictability and the focus are on maintenance of internal organisational stability through rules and regulations. Leaders tend to be conservative and cautious. Organisational success is defined in terms of control and stability and climate is characterised as one of rigidity.*

- *Rational culture emphasises performance in terms of organisational goal fulfilment and achievement and in this culture motivation comes from a desire to achieve external competitive advantage. Leaders are viewed as goal directed often restructuring and defining success in terms of market position and access to external resources.*

  (Adapted from Gerowitz 1996)